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PHYSICIAN/PATIENT PAIN MEDICATION CONTRACT

On February 15, 2017, the Governor signed legislation that implements his plan to increase insurance coverage for addiction treatment and provide additional safeguards to limit the abuse of opioids, including, limiting the initial opioid prescriptions for acute pain to 5 days and signing a pain medication contract for the extended use of opioids.

The long-term use of such substances is controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also a risk for an addictive disorder developing or of relapse occurring in a person with prior addiction. The extent of this risk is not certain. Because these drugs have potential for abuse or diversion, it is important to use opioids in accordance with your physician's orders.

For this reason the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of the physician whose signature appears below to continue prescribing opioids to treat your chronic pain.

I, _____, understand and voluntarily agree to the following *(initial each statement after reviewing)*:

_____ 1. All controlled substances must come from the physician whose signature appears below or, during his or her absence, by the covering physician, unless specific authorization is obtained for an exception. (*Multiple sources can lead to untoward drug interactions or poor coordination of treatment).*

_____ 2. All controlled substances must be obtained at the same pharmacy, where possible. The pharmacy that I have selected is:

Pharmacy:_____
Phone:_____

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_____ 3. It is my obligation and responsibility to inform the undersigned physician of any new medication or medical conditions, and of any adverse effects I experience from any of the medications that I take.

_____ 4. I will use my medication, (name of medication) _____, at a rate no greater than the prescribed rate and I understand that use of my medication at a greater rate will result in my being without medication for a period of time and may lead to medical complications. Changes in medication and/or dosage may occur during the course of treatment and alternative modes of treatment may be part of the treatment. My current pain management plan is:

_____

_____

_____ 5. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professional who provide my health care for purposes of maintaining accountability and for continuity of care.

_____ 6. **I WILL NOT SHARE, SELL,** or otherwise permit others to have access to these medications.

_____ 7. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependence and should be closely safeguarded. Additionally, the medication may be hazardous or lethal to a person who is not tolerant to their effects, especially a child. I will take the highest possible degree of care with my medication and prescription. They will not be left where others might see or otherwise have access to them. I will dispose of all unused medication in a Project Medicine Drop Box, through a Take-Back program or in a drug disposal pouch.

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_____ 8. Medication **WILL NOT** be replaced if it is lost, gets wet, is destroyed, left on an airplane, etc. If my medication has been stolen and I complete a police report regarding the theft, an exception may be made, however that is up to the discretion of the physician.

_____ 9. Early refills **WILL NOT** be given for this medication.

_____ 10. If the responsible legal authorities have questions concerning my treatment, as might occur, for example, if I were obtaining opioid medication at several pharmacies, all confidentiality is waived and these authorities may be given access to the records of the undersigned physician or his/her medical practice concerning opioid administration.

_____ 11. All refills of prescriptions for pain medications will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends. Refills are contingent on keeping scheduled appointments. I will not phone for prescriptions after hours or on weekends.

_____ 12. The risks and potential benefits of these therapies have been explained to me.

_____ 13. I agree not to use illegal drugs or alcohol while taking this medication.

_____ 14. I should not drive a motor vehicle or operate machinery if the medication causes dizziness, drowsiness or sedation.

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_____ 15. I may need to submit to random urine drug testing and pill counts if requested by my physician, and my physician will verify that I am receiving controlled substances from only one prescriber and only one pharmacy by checking the Prescription Monitoring Program Website.

_____ 16. If I do not follow all the terms of this Agreement my physician may stop prescribing pain medications, and/or I may be required to find another physician or healthcare professional for my future medical treatment.

You affirm that you have the full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all of its terms.

_____ Patient Name

_____ Physician Name

_____ Patient Signature

_____ Physician Signature

_____ Date

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