IN TOUCH ADULT HEALTH NPS PC
Pain Management Opioid Agreement Contract

The purpose of this agreement is to give you information about the medications you will be taking for pain management and to assure that you and your Nurse Practitioner comply with all state and federal regulations concerning the prescribing of controlled substances. A trial of opioid therapy can be considered for moderate to severe pain with the intent of reducing pain and increasing function. The Nurse Practitioners goal is for you to have the best quality of life possible given the reality of your clinical condition. The success of treatment depends on mutual trust and honesty in the Nurse Practitioner/patient relationship and full agreement and understanding of the risks and benefits of using opioids to treat pain.

PLEASE BE AWARE FROM THIS DAY FORWARD ANY INCONSISTENCIES IN YOUR URINE TOXICOLOGY SCREENS WILL RESULT IN IMMEDIATE TERMINATION FROM THE PRACTICE. INCONSISTENT TOXICOLOGY SCREEN IS DEFINED AS: (1) USE OF ALCOHOL, (2) USE OF ILLEGAL DRUGS, (3) MEDICATIONS NOT PRESCRIBED TO YOU, AND (4) MEDICATIONS THAT ARE PRESCRIBED TO YOU, HOWEVER, ARE COMPLETELY NEGATIVE IN YOUR TOXICOLOGY SCREEN. _____INITIAL

I have agreed to use opioids as part of my treatment for chronic pain. I understand that these drugs can be very useful, but have a high potential for misuse and are therefore closely controlled by the local, state, and federal government. My Nurse Practitioner is prescribing such medication to help manage my pain, I agree to the following conditions:

1. **I am responsible for my pain medications. I agree to take the medication only as prescribed.**

a. I understand that increasing my dose without the close supervision of my Nurse Practitioner could lead to drug overdose causing severe sedation, respiratory depression and even death.

b. I understand that decreasing or stopping my medication without the close supervision of my Nurse Practitioner can lead to withdrawal. **Withdrawal symptoms** can include yawning, sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot and cold flashes, "goose flesh", abdominal cramps, and diarrhea. These symptoms can occur 24-48 hours after the last dose and can last up to 3 weeks. _____ **INITIAL**

2. **I will not request or accept controlled substance medication from any other physician/provider or individual while I am receiving such medication from my Nurse Practitioner at In Touch Adult Health NPs PC. _____INITIAL**

3. There are side effects with opioid therapy, which may include, but not exclusively, skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation, or the possibility of impaired cognitive (mental status) and/or motor ability. Overuse of opioids can cause decreased respiration (breathing).

It is my responsibility to notify my Nurse Practitioner of any side effects that continue or are severe (i.e., sedation, confusion). I am also responsible for notifying my Nurse Practitioner immediately if I need to visit another physician or need to visit an emergency room due to pain, or if I become pregnant. _____**INITIAL**

4. **I understand that the opioid medication is strictly for my own use. The opioid should never be given or sold to others because it may endanger that person's health and is against the law.** _____**INITIAL**

5. I should inform my providers of all medications I am taking, including medications like Valium or Ativan; sedatives such as Soma, Xanax, Fiorinal; antihistamines like Benadryl; herbal remedies, alcohol, and cough syrup containing alcohol, codeine, or hydrocodone can interact with opioids and produce serious side effects. _____**INITIAL**

6. During the time that my dose is being adjusted, I will be expected to return to the clinic as instructed by my Nurse Practitioner. _____**INITIAL**

7. Any evidence of drug hoarding, acquisition of any opioid medication or adjunctive analgesia from other physicians (which includes emergency rooms), uncontrolled dose escalation, loss of prescriptions, or failure to follow the agreement may result in termination of the Nurse Practitioner/patient relationship. _____**INITIAL**

8. I will communicate fully with my Nurse Practitioner to the best of my ability at the initial and all follow-up visits my pain level and functional activity along with any side effects of the medications. _____**INITIAL**

9. **I will not use any illicit substances, such as cocaine, marijuana, etc. while taking these medications. This will result in complete termination of the Nurse Practitioner/patient relationship and discharge from the practice.** _____**INITIAL**

10. **The use of alcohol together with opioid medications is contraindicated and will result in immediate discontinuation of controlled substance and discharge from the practice.** _____**INITIAL**

11. I am responsible for my opioid prescriptions. I understand that:

a. Refill prescriptions can be written for a maximum of one month supply and will be filled at the **same pharmacy.**

Pharmacy: _____ Phone number: _____

b. **It is my responsibility to contact the office for prescription refills 7 days prior to due date.**

c. **I am responsible for keeping my pain medications in a safe and secure place, such as a locked cabinet or safe. I am expected to protect my medications from loss or theft. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. If my medication is stolen I will report the stolen medication to my Nurse Practitioner. However, if my medications are lost, misplaced, or stolen my Nurse Practitioner WILL NOT fill medication early and/or discontinue the medications.** _____**INITIAL**

d. Refills will not be given as an "emergency", such as on Friday afternoon because I suddenly realize I will "run out tomorrow". Refills will not be given after office hours or on weekends. _____**INITIAL**

e. Refills can only be filled by a pharmacy in the State of New York. _____**INITIAL**

f. Prescriptions for pain medicine or any other prescriptions, or change of medication or dosage will be done only during an office visit and during regular office hours. **No** refills of any medications will be done during the evening or on weekends.

g. **You must bring back all opioid medications and adjunctive medications prescribed by your Nurse Practitioner in the original containers/bottles at every visit. Failure to bring medications to your office visit may result in cancellation of your office visit.** _____**INITIAL**

h. Prescriptions will not be written in advance due to vacations, meetings, or other commitments. _____INIT

12. While physical dependence is to be expected after long-term use of opioids, **signs of addiction, abuse, or misuse shall prompt the need for substance dependence treatment as well as weaning and detoxification from the opioids.** _____**INITIAL**

a. **Physical dependence** is common to many drugs such as blood pressure medications, anti-seizure medications, and opioids. It results in biochemical changes such that abruptly stopping these drugs will cause a withdrawal response. It should be noted that physical dependence does not equal addiction. One can be dependent on insulin to

treat diabetes or dependent on prednisone (steroids) to treat asthma, but one is not addicted to the insulin or prednisone. _____**INITIAL**

b. **Addiction** is a primary, chronic neurobiologic disease with genetic, psychosocial and environmental factors influencing its development and manifestation. It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and cravings. This means the drug decreases one's quality of life. If the patient exhibits such behavior, the drug will be tapered and such a patient is not a candidate for an opioid trial. He/she will be referred to an addiction medicine specialist. _____**INIT**

c. **Tolerance** means a state of adaptation in which exposure to the drug induces changes that result in a lessening of one or more of the drug's effects over time. The dose of the opioid may have to be titrated up or down to a dose that produces maximum function and a *realistic* decrease of the patient's pain. _____**INITIAL**

If it appears to the Nurse Practitioner that there is no improvement in my daily function or quality of life from the controlled substance, my opioids may be tapered/discontinued. I will gradually taper my medication as prescribed by the Nurse Practitioner. _____**INITIAL**

13. If I have a history of alcohol or drug misuse/addiction, I must notify my Nurse Practitioner of such history since the treatment with opioids for pain **may** increase the possibility of relapse. A history of addiction does not, in most instances, disqualify one for opioid treatment of pain, but starting or continuing a program for recovery **is a necessity. _____INITIAL**

14. I agree and understand that my Nurse Practitioner reserves the right to perform random or unannounced urine drug testing. If requested to provide a urine sample, I agree to cooperate. If I decide not to provide a urine sample, I understand that my Nurse Practitioner may change my treatment plan, including safe discontinuation of my opioid medications when applicable or complete termination of the Nurse Practitioner/patient relationship. The presence of a non-prescribed drug (s), illicit drug (s), alcohol, or opiates that are prescribed and negative in your urine WILL BE grounds for termination of the Nurse Practitioner/patient relationship. Urine drug testing is done for my benefit as a diagnostic tool and in accordance with certain legal and regulatory materials on the use of controlled substances to treat pain. _____**INITIAL**

I agree to a family conference or a conference with a close friend or significant other *if the Nurse Practitioner feels it is necessary*. _____**INITIAL**

15. I understand that non-compliance with the above conditions may result in a re-evaluation of my treatment plan and discontinuation of opioid therapy. I may be gradually taken off these medications, or even discharged from In Touch Adult Health NPs PC. _____**INITIAL**

I _____ have read the above information or it has been read to me and all my questions regarding the treatment of pain with opioids have been answered to my satisfaction. I hereby give my consent to participate in the opioid medication therapy & acknowledge receipt of this document.

Patient's Signature_____
Date_____

Witness's Signature_____
Date_____