

SAMPLE MEDICATION MANAGEMENT AGREEMENT

Patient name: _____ MRN#: _____

Doctor: _____

Goals for taking opioid medications: _____

Medication and proposed duration of use: _____

- Only your pain doctor will prescribe opioid medications for you.
- You agree not to ask for opioid medications from any other doctor.
- You agree to keep all scheduled appointments, not just with your physician, but also with recommended therapists and psychological counselors. Three or more missed appointments or same day cancellations will lead to patient dismissal.
- You agree to provide regular samples for drug screens. Positive tests for any illegal substances will result in your dismissal and referral elsewhere for substance abuse evaluation and management.
- No prescriptions will be refilled early.
- No prescriptions will be refilled if you lose, destroy, or have any of your medication stolen.
- Prescription refills will be authorized only during regular office hours. If you want the prescription mailed to you, contact our office seven working days prior to the refill date. If you want to pick up the prescription in person, call two working days in advance of renewal date.
- You agree to comply fully with all aspects of your treatment program including behavioral medicine (psychology/psychiatry) and physical therapy, if

recommended. Failure to do so may lead to discontinuation of your medication and referral to an outside physician.

- Successful pain management entails employing multiple interventions, including active participation in regular physical exercise and the use of psychological coping strategies. A pattern of passive reliance on medications, resistance to more active physical treatments, and repeated failure to demonstrate the implementation of psychologically based coping strategies that have been taught to you may lead to discontinuation of medications and/or referral to an outside physician.

We understand that emergencies can occur and under some circumstances, exceptions to these guidelines may be made. Emergencies will be considered on an individual basis.

Opioids may cause drowsiness that can be worsened with alcohol, benzodiazepines, and other sedating medications. Use care when driving or operating machinery. An overdose can cause severe side effects, even death.

Other common, usually temporary, side effects include nausea, itching, and sweating. Psychological depression and lowered testosterone levels (in men) may also occur. Sleep apnea, if present, may be worsened by opiates. Constipation commonly occurs, and often does not improve with time. It is impossible to predict opioid side effects in any individual patient. Having side effects on one opiate does not necessarily mean there will be side effects on another opioid.

You must take opioids only as directed. Federal law prohibits giving this medication to anyone else. Physical dependence will develop with regular use, but does not by itself indicate addiction. A withdrawal syndrome will develop if you stop your medication abruptly. Tolerance may develop to the pain relief effects of opioids, but in chronic pain states usually occurs slowly, if at all.

Not all pain conditions respond to opioids. Some pain may only be partially responsive to opioid therapy. Total elimination of pain is an unrealistic goal. Escalating dosages may indicate that opioids are not effective or that there is an underlying problem with addiction or psychological dependence. Discontinuation of opioid medications may need to be done under these circumstances.

I, the undersigned, agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered.

I give permission to my pain doctor to contact my other healthcare providers, for the purposes of sharing information concerning my situation, as is deemed necessary for coordinated, high quality care.

If I do not follow these guidelines fully, my doctor may taper and stop opioid treatment and refer me elsewhere for care.

A copy of this document has been given to me.

Patient signature: _____ Date: _____

Witness signature: _____

Courtesy of P. Fine, MD, of University of Utah Hospitals and Clinics Pain Management Center.