

Agreement on Opioid Therapy

I understand that Dr. _____ (hereafter known as “my provider”) is prescribing opioid medication to assist me in managing chronic pain that has not responded to other treatments. The goal of the opioid therapy will be to assist me to improve my daily functioning. If my activity level or general functioning gets worse, the medication may be changed or discontinued. The risks, side effects and benefits have been explained to me and I agree to the following conditions of opioid treatment. I understand that my doctor/NP/PA is under no obligation to provide these medications to me, and that he or she reserves the right to discontinue these medications at any time. **Additionally, failure to adhere to these conditions below will result in discontinuing the opioid medication.**

1. I agree to participate in **other treatments**, which my provider recommends, and will be ready to taper or discontinue the opioid medication, as other effective treatments become available.
2. I will take my medications exactly **as prescribed** and will not change the medication dosage or schedule without my provider’s approval.
3. I will keep **regular appointments with** my provider and all other providers as recommended. Two appointment cancellations with less than one working day’s notice or two no-show appointments may constitute grounds for immediate termination of this agreement.
4. All opioid and other controlled drugs for pain must be prescribed only by _____.
5. If I have **another condition** that requires the prescription of a controlled drug (like narcotics, tranquilizers, barbiturates, or stimulants), or if I am **hospitalized** for any reason, I will inform my provider within **one business day**.
6. I will designate **one pharmacy** where all of my prescriptions will be filled.

Pharmacy Name: _____

Phone Number: _____

Fax Number: _____

Address: _____

7. I understand that lost or stolen prescriptions will **not be replaced**, and I will not request early refills.
8. I agree to **abstain from all illegal drugs**. I will avoid the use of alcohol if directed to do so by my provider. I will provide urine or blood specimens at my provider’s request to monitor my compliance.
9. I am responsible for keeping track of the medication left and plan ahead for arranging refills in a timely manner so that I will not run out of medications.
 - a. Refills will be made only during regular office hours, which are 8am to 4pm.
 - b. Refills will **not** be made at night, Friday’s after 12:00 noon, weekends or during holidays.
 - c. Please plan ahead and allow at least 2 days for prescriptions that will be faxed to your pharmacy and 5 days for prescriptions that must be mailed to your pharmacy. Schedule 2 prescriptions must be mailed and schedule 3-5 prescriptions will be faxed. You are taking a schedule ____ medication.

Patient Name (print): _____ Date: _____

Pt Signature: _____ Provider sig: _____