Medication Management Agreement: *Opioids*

Prescribing provider: _____ Facility: _____ Date: _____

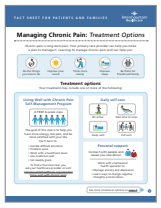
Patient name: _____ **Date of birth:** _____ MRN: _____

Parent/legal guardian name (if patient is younger than 18 years): _____

The terms "I," "my," and "you" in this document refer to the patient. Where the patient is younger than 18 years or an adult for whom a guardian is signing the Agreement, the terms "I," "my," and "you" refer to the patient and his or her parent or guardian.

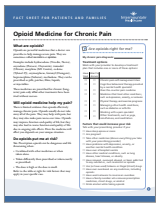
This document lists commitments you must make before you begin treatment with opioid medicine.

Options for pain management



1. I understand that there are other treatments for pain that do not involve taking opioid medicines, as outlined in the *Managing Chronic Pain* fact sheet. I agree to follow the recommendations of my prescribing provider to explore other treatment options.
2. I understand that this medicine is being recommended because my pain is severe and other treatments have not helped my pain enough.
3. I understand that opioid medicine is not intended to completely get rid of my pain. The purpose of the medicine is to help reduce my pain and make it easier to function.

Risks and side effects



1. I understand that there are many risks and side effects with opioid medicines. I have read the *Opioid Medicine for Chronic Pain* fact sheet and considered related education materials shared by my provider.
   - I have had detailed discussions with my prescribing provider about the risks and benefits of taking opioids.
   - I have decided the possible benefits of taking opioid medicine outweigh the risks. If at any time I feel the side effects outweigh benefits or the medicine is not controlling my pain enough, I will discuss this with my provider.
2. I am aware that opioids are risky when taken alone and may be more dangerous if combined with other drugs and medicines.
   - I will tell my prescribing providers about all prescriptions, patches, and over-the-counter medicines I use now or may use in the future.
   - I will tell my prescribing provider if I drink alcohol, smoke, or use street drugs.
3. I understand that opioid side effects, including respiratory depression (breathing difficulty) and death, greatly increase when the dose is being adjusted or when switching from one opioid to another.
4. I will tell my prescribing provider if I use cannabis (marijuana) or cannabinoid (CBD) products. I understand that my prescribing provider may stop prescribing me opioid medicines if I am using cannabis or CBD.

Preventing misuse

1. I understand that opioid medicines have the potential for misuse and careful monitoring may be required. If requested, I will:
   - Bring my opioid medicine to each visit.
   - Agree to random pill counts and drug screening (urine, saliva, or blood).
   - Keep all healthcare appointments.
2. I understand that my opioid medicines could be misused by someone else, and would be very dangerous to them. For this reason, I must be able to account for all of my opioid medicine.
   - I agree to secure my opioid medicine in a safe location such as a lockbox. If I do not secure my opioid medicine properly, my provider may stop prescribing it for me.
   - I will not sell, share, or otherwise permit others to have access to opioid medicines prescribed for me.

Taking opioids as directed

1. I understand that increasing my dose or altering my medicine could lead to multiple dangerous effects including, but not limited to, respiratory depression, severe sedation (unconsciousness), and death.
   - I will take my medicine as prescribed and follow all the instructions given by my prescribing provider.
   - I will never increase my opioid dose without getting approval from my prescribing provider.
   - I will never crush, chew, or alter my medicine in any way except as instructed by my prescribing provider.

2. I agree to never use alcohol or illegal drugs while I am taking opioid medicine.
3. I understand that opioid medicines could limit my ability to drive or operate machinery.
   - I understand that this limitation can persist as long as I am taking these medicines. The passage of time does not necessarily decrease the risk.
   - I understand other medicines or drugs may also limit my judgment, reaction time, and ability to drive. This includes, but is not limited to, benzodiazepines, muscle relaxants, sleep aids, and some over-the-counter medicines. This limitation may become even more severe when taken with opioids.

Filling your prescription

1. I understand that on-call physicians (those available nights and weekends) will typically not prescribe opioids. I understand that if I run out of opioids early, I may have withdrawal symptoms.
2. I agree to never get opioids from nonmedical sources (family, friends, or others).
3. I understand that for my safety it is recommended that I get my opioid medicine from one pharmacy. My prescribing provider may make this a requirement as part of my treatment.
4. In the event I am hospitalized, I will only take opioids under the direction of the hospital provider until I can follow up with my prescribing provider. I will inform both providers of all the medicines I am taking to keep me safe.

Ending your opioid prescription

1. I understand that certain situations may arise that would lead my prescribing provider to decide to no longer prescribe opioid medicines. Examples include if:
   - A change in my medical situation makes opioids riskier.
   - Opioid medicine is not managing my pain or my function is not improving.
   - I was to misuse, abuse, or allow others to have access to my medicine.
   - I show signs and symptoms of addiction. (Note: The presence of addiction does not absolutely rule out the possibility of using opioid medicines in some cases.)
   - I do not follow through with the recommended treatment plan, including what is described in this agreement.

By my signature below, I affirm that I am aware of the possible risks and benefits of opioids and of other treatments not involving the use of opioids. I have read this form or had it read to me. I have also read the "Opioid Medicine for Chronic Pain" fact sheet and reviewed other education materials, as shared by my prescribing provider. I have had the chance to ask questions, and all of my questions have been answered in a way that I understand. I have been informed and clearly understand the above issues regarding pain treatment pain with opioid medicine.

I understand and accept all of these terms. I give my consent for pain treatment with opioid medicine.

Patient or Patient's Representative (required): _____ Date: _____

Mature Minor Patient*: _____ Date: _____

*(*Patients aged 12 to 17 years should sign in addition to the parent or guardian.)*

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