***Sample Template – Overview for the PROVIDER***

***Patient-Provider Agreement for Ongoing Use of Opiate (Narcotic) Medication***

**Please note:**

This document is a template that can be modified by anyone who wishes to use it in their clinical practice.

The ***Agreement*** is signed by provider and patient thereby fulfilling the State of Michigan requirement for a Bona Fide relationship when prescribing controlled substances. This is different from the Start Talking Form where the patient consents to the Narcotic / Opiate prescription.

This ***Agreement*** is more comprehensive as the course of treatment will be over months and possibly years.

Initial Visit

* Detailed pain history: quality, location, radiating patterns, exacerbating factors, associated injuries/events at original onset
* Pain treatment history: consultants seen, interventions or surgeries performed, medications tried and their perceived effectiveness, rehabilitation therapy completed, reasons for leaving previous providers
* Psychosocial history: psychiatric evaluations and/or diagnoses, family status and living arrangements, social support, employment history (including worker’s compensation claims), educational level, financial resources and stressors, history of physical or sexual abuse
* Substance history: alcohol, illicit drugs, smoking, heavy caffeine use
* Family history: chronic pain syndromes, psychiatric illness, disability, substance abuse, alcoholism
* Verification: review available local and outside documentation to assess consistency of history provided
* Functional status: capacity and disability in work, family and recreational domains
* Physical examination and diagnostic testing: as appropriate

For patients being considered for, or already receiving, chronic daily opioid therapy: check comprehensive drug screen = EIA + GCMS and search State prescription monitoring programs

Management Plan

* Goals: establish with patient realistic treatment goals for functional improvement or maintenance, not analgesia alone
* Lifestyle interventions: exercise, weight management, smoking cessation, sleep hygiene.
* Psychiatric co-morbidities: manage (treat or refer), e.g., depression, anxiety, molestation, substance abuse, personality disorders, schizophrenia, PTSD
* Physical modalities: consider physical therapy, massage, acupuncture
* Medications: select based upon presumed pain type: Somatic (nociceptive) pain; Neuropathic pain; Centralized pain

**If initiating opioid therapy:**

* Assess risk for addiction
* Present opioids as a tool to help reach functional improvement goals; be clear that opioids will be continued only if they contribute to functional improvement or maintenance
* Establish prescribing practices: Agreement between Patient & Provider; one prescriber/one pharmacy, no after-hours refills, compliance with adjuvant therapies, random urine drug screens, required follow-up at scheduled intervals.
* Follow-up Visits (weekly to quarterly)
* Progress: document adherence, progress toward functional goals, and pain response
* Adverse effects: evaluate for adverse effects of medications (NSAIDs, adjuvants, opioids); assess addiction behavior: monitor ‘red flag’ drug-taking behavior (urine comprehensive drug screening results positive for non-prescribed or illicit substances, or the absence of a prescribed medication, overwhelming focus on opiates, requests for early refills, reports of lost, spilled or stolen opiates, concurrent alcohol or substance abuse, forgery of prescriptions, evidence of diversion of controlled substances, illegal activities with prescriptions)
* Review management plan: refine functional goals, titrate effective medications, stop ineffective medications (including NSAIDs and opioids), modify non-interventional modalities, review expectations
* Referral: consider referral to appropriate specialist(s) (e.g., Comprehensive Pain Management Center) if evidence of addiction behavior, failure to reach functional goals despite adherence to plan, rapidly escalating or very high dose opioid need, poor psychological adjustment to symptoms.

Long Term Management

* Check MAPS quarterly.
* Order a urine comprehensive drug screen , EIA + GCMS, on all patients twice per year – once during

January-June and another July-December (check with your lab provider for details on how to interpret the results)

* Review management plan annually: refine functional goals, titrate effective medications, stop ineffective medications (including NSAIDs and opioids), modify non-interventional modalities, review expectations.
* Assure that the Agreement is scanned / included in the medical record

In addition:

Consider prescribing **Naloxone** (Narcan 4mg intranasal spray) to all patients for whom you will be prescribing long term Opiate (Narcotic) Medications. This is particularly important for patient who are also prescribed Benzodiazepines or who are on medicines that can cause sedation.

Consider using a tool to facilitate the patient conversation regarding their pain and treatment goals.

* Ottawa Personal Decision Guide
* Personal Care Plan for Chronic Pain
* PEG Scale Assessing Pain Intensity and Interference (Pain, Enjoyment, General Activity)

This Agreement can also be used when prescribing **Buprenorphine**.

Additional language that may be added:

* If I miss an appointment or lose my medication, I understand that I will not get more medication until my next office visit. I may also have to start having supervised buprenorphine dosing.
* I understand that it is illegal to give away or sell my medication – this is diversion. If I do this, my treatment will no longer include unsupervised buprenorphine dosing and may require referral to a higher level of care, supervised dosing at the clinic, and/or a change in medication based on the doctor’s evaluation.
* I understand that random urine drug testing is a treatment requirement. If I do not provide a urine sample, it will count as a positive drug test.
* I understand that initially I will have weekly office visits until I am stable. I will get a prescription for 7 days of medication at each visit. I can be seen every two weeks in the office starting the second month of treatment if I have two negative urine drug tests in a row. I will then get a prescription for 14 days of medication at each visit.
* I understand that people have died by mixing buprenorphine with other drugs like alcohol and benzodiazepines (drugs like Valium®, Klonopin® and Xanax®).
* I understand that treatment of opioid addiction involves more than just taking my medication. I agree to comply with my doctor’s recommendations for additional counseling and/or for help with other problems.
* I understand that there is no fixed time for being on buprenorphine and that the goal of treatment is to stop using all illicit drugs and become successful in all aspects of my life.
* I understand that I may experience opioid withdrawal symptoms when I go off buprenorphine.

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_\_\_ **Patient identifier:** \_\_\_\_\_\_\_\_\_\_\_\_

***Sample Template***

***Patient-Provider Agreement for Ongoing Use of Opiate (Narcotic) Medication***

**Purpose of Agreement**: To protect your access to controlled substances and to protect the provider and/or clinic in prescribing to you. We used to believe that using opioids for long-term pain was safe. We now know that opioids can be harmful. Using opioid medicine is risky, and can cause overdose and addiction. There is also the risk of becoming addicted or having a relapse if you have a history of prior addiction. The extent of this risk is not certain. Because these drugs are likely to be abused, there are strict rules set by the State of Michigan law.

*Our office will review this agreement with you so that you get the best pain relief and you know how to lower the chances of possible harm to yourself and others while you are taking this medication. This agreement also lays out the rules for getting opioids including the role of our clinic and your provider.*

* The use of the following medicine(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Is only one part of my treatment for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* The Primary Prescribing Doctor is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Terms you should know:**

* Psychological dependence – It is possible that stopping the drug will cause you to miss or crave it.
* Tolerance – You may need more and more drug to get the same effect.
* Addiction – You may become dependent on a drug and unable to stop using it without suffering unsafe effects.
* Overdose – Taking more than the amount of medication prescribed to you or using with alcohol or other drugs can cause you to stop breathing, causing a coma, brain damage, or even death.

**The goals of this medicine are:** *(Please check the goals that apply to you.)*

* to improve my day to day function at work and at home
* to help reduce my pain as much as possible without causing unsafe side effects
* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Opioid medications will not get rid of my pain fully. The goal for treating my pain is to improve my day to day function. Being able to do fun things such as walking, deep breathing and mindfulness meditation (careful awareness of deep thinking) can sometimes be as or more effective than opioid medicine.

My provider will work with me to find other options to opioid medicines to control my pain and improve my day to day function.

**What should I know about this medication?**

Opioid medications often have side effects, which may include, but are not limited to:

* Itching or rash
* Severe constipation; trouble urinating or passing stool
* Depression getting worse
* Problems thinking clearly or sleepiness

Using pain-relieving medications with alcohol, illegal or illicit drugs, or benzodiazepines can cause:

* Overdose
* Trouble breathing
* Death

**Other risks:**

* Opioids can cause sleepiness, decreased response time, affect decision-making, and increase tolerance. Thus, it can be unsafe for me to operate heavy gear or drive while taking opioids.
* **Pregnancy:**  If I am pregnant or thinking about becoming pregnant, I should discuss taking an opioid medication with my provider prior to taking any medications.
* **Physical dependence:** Stopping the use of a drug quickly may cause withdrawal symptoms, which could include: runny nose, stomach cramping, rapid heart rate, loose stool, sweating, anxiety, bad temper, problems sleeping, or goose bumps.

If I must stop this medicine for any reason, I need to stop it slowly. Stopping it slowly will help me avoid feeling sick (examples listed above). If I decide to stop my medication, I will contact my doctor.

**Ways to lower harm from this medication:**

To lower my chances for harm from my opioid medication I agree that:

* I will take my opioid medication as prescribed. I will not take more than my prescribed amount without being told by my provider. This means I will not run out of my medication early.
* I agree to take only the opioid medication prescribed to me, even if another person offers me the same opioid medication, or another opioid medication that I have used in the past.
* I will not take street drugs or illegal drugs, those not prescribed to me, or abuse alcohol.
* I will not operate motor-powered tools or gear after starting an opioid medication or after a change (such as a dose increase) until I know how the medicine affects me. I will not drive or operate motor-powered equipment if I ever feel drowsy, dizzy, or not quite myself.
* Theft or illegal use of opioid medications is common. They can even be stolen out of my home by visitors or curious young people. Therefore, I will hide or secure my opioid medications. I will consider using a lock box or another way to lock up my opioid medications.
* I will get rid of any unused opioid medications in a safe way, such as at a drop box at certain pharmacies or police departments. I can find safe drop off locations at www.takebackyourmeds.org.
* I know the clinic must notify the police if it believes there is illegal action relating to my opioid medication, such as selling or giving away my opioid medication to other people.

If I take this medicine and drink alcohol, use illegal drugs or use drugs prescribed by other providers:

* I may not be able to think clearly
* I could risk hurting myself (such as a car crash)
* I could become ill or even die

My doctor can only prescribe this medicine if I do not use illegal drugs. If I do not use this medication exactly as prescribed, I risk hurting myself and others.

I am in charge of my medicine.

* I know my medicine will not be replaced if it is lost. If my medication has been stolen and I complete a police report about the theft, an exception may be made.
* I will not share my opioid medications with anyone or sell them to anyone. This violates federal law and will cause my provider to stop prescribing opioids to me.

I agree to tell my doctor, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, within 48 hours, if I have a drug overdose so that we can adjust my medication dose and discuss how to be safe while taking these medicines.

* I will be given a prescription for Naloxone and taught about its use as a rescue agent in case of overdose.

**I agree to the following:**

I will keep all appointments set up by my doctor (e.g., primary care, physical therapy, mental health, substance abuse treatment, pain management).

* I will be on time for appointments. If I arrive late to an appointment for prescription refills, my appointment may be rescheduled.
* If I miss my appointments, it may not be safe for me to stay on this medicine.
* I will bring my pill bottles with any pills that are left to each clinic visit.

I will only use one pharmacy to fill these prescriptions. My preferred pharmacy is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, in the city of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_and the phone number is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

When asked, I will give a urine and/or blood sample to help monitor my treatment. I understand that clinic policy requires regular testing.

* My doctor will check my prescription fill history by Michigan Automated Prescription System (MAPS) as required by State of Michigan Law and may call my pharmacy.
* If my doctor decides that the risks outweigh the benefits of this medicine, my medicine will be stopped in a safe manner.

I can only get this prescription from my primary prescribing doctor’s office.

* I will not get controlled medications from other providers (including dentists, the Emergency Room, specialists or other providers), without checking with my primary prescribing doctor.
* Refills will be given only during normal office hours. Clinic policy prevents on-call doctors from giving controlled-substance prescriptions.
* I will not call between appointments, or at night or on the weekends looking for refills. I understand that prescriptions will be filled only during scheduled office visits.

**My provider agrees to:**

As your doctor, I agree to perform regular checks to see how well the medicine is working. I agree to provide primary care for you even if you are no longer getting controlled medicines from me.

We are making a promise to work with you in your efforts to get better. To help you in this work:

* We will help you plan regular appointments for medicine refills. If we have to cancel or change your appointment for any reason, we will make sure you have enough medication to last until your next appointment.
* We will make sure that your treatment is as safe as possible. We will check often to make sure you are not having bad side effects.
* We will keep track of your prescriptions and test for drug use often to help you feel like you are being watched well.
* We will help connect you with other forms of treatment to help you with your care and goals.
* We will help set treatment goals and monitor your progress in reaching those goals.
* We will work with any other doctors or providers you are seeing so that they can treat you safely and well.
* We will work with your medical insurance providers to make sure you do not go without medicine because of paperwork or other things they may ask for.
* If you become addicted to these medications, we will help you get treatment and get off of the

medications that are causing you problems safely, without getting sick.

**What are reasons for ending the agreement?**

I may not be able to obtain controlled prescriptions from this clinic if I take more medication than is prescribed, if I fail to give requested urine or blood for testing, if those tests fail to contain the proper amounts of my prescribed medication, if non-prescribed medications (from friends, other prescribers, the ED, street purchases) are present, or if illegal drugs are present.

I may not be able to be seen in this clinic if I am disruptive or threaten clinic staff. I understand that under State of Michigan law, the non-medical use of controlled substances (lying to get medications, giving or selling these medicines to others) is a crime and will result in the end of my controlled substance treatment.

*By signing below, I agree that I have read and understood the information above. Any questions I have about this agreement have been answered. If I am not able to keep the promises made in this agreement, I will inform you. I understand that if I do not follow this agreement, my provider can choose to stop giving me my opioid medication treatment. If this occurs, I understand that the clinic will let me know this in person or will contact me at my last known address or phone number.*

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_