

Interventional PAIN CARE, LLC

Policy on Opioid Drugs for Non-Cancer Pain and Patient Medication Agreement

I understand that I have a pain problem that has failed to respond to other treatments. It is recommended that I begin or continue the use of opioid analgesics to relieve pain and increase my daily function. I understand there are risks of addiction and adverse effects related to the use of these medications. I must assume the responsibility for their proper use, and accept many risks associated with this treatment. The benefits I hope for are improved function and pain reduction. Failure to comply with the guidelines below may result in terminating the opioid medication and dismissal from care of this practice.

I am expected to adhere to the following:

1. Only this practice will be responsible for all opioid prescriptions for me. If there is evidence of medications being obtained or requested from any other source, my provider may choose not write further prescriptions, and detoxification may be recommended. Reasonable exceptions will be made for emergency care of acute problems.
2. It is my responsibility to notify new and existing health care providers that I am on opioid therapy.
3. All opioid prescriptions and my other medications will be filled at one pharmacy only. It is very important for the pharmacist to be a part of my pain management team. This will add an important safety component in my health care.
4. Opioids will be written on a monthly basis. My health care provider will determine my follow-up appointments. Changes will not be made without an evaluation by my health care provider.
5. A monthly supply of medication will be available with a specific dose and fixed amount. It is my responsibility to make this medication last the intended interval.
6. Lost or stolen prescriptions will not be replaced. It is my responsibility to safeguard my medication. I realize that the consequences of not doing so will result in not having my medication for a period of time. I will experience withdrawal symptoms.
7. Doses will not be increased over the phone. If the amount of opioid medication I am on is not adequately controlling my pain, then I must make an appointment for re-evaluation. I will notify my provider immediately in the event of an adverse reaction to the medication.
8. I must show signs of improved function and increased daily activities to continue in this program.

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9. I must adhere to all prescribed therapies, such as physical therapy, psychological counseling, and treatment with other medication.
10. My health care provider will determine follow-up care and clinic appointments for re-evaluation of effectiveness of medication and to watch for adverse reactions.
11. I agree not to drink alcohol or use illicit drugs while taking this medication. Doing so may result in discharge from the program, and I agree to provide urine or other body fluid samples for testing whenever requested by this practice. I understand that to refuse will be grounds for possible immediate dismissal. I will not receive any prescriptions for medication if I fail to provide the requested specimen.
12. I agree not to share, trade, or sell my medications.
13. I understand the potential side effects of these types of medications, including drowsiness, disorientation, stomach upset, constipation, and inability to drive or operate machinery (as outlined below in “Risks of Opioid Treatments”). I agree not to drive a vehicle or operate equipment if I am drowsy or impaired.
14. I am willing to obtain appropriate addiction treatments for drug or alcohol dependence.
15. I will adhere to all aspects of my treatment plan.
16. I will treat the staff with respect. I can expect the staff to treat me with the same respect.
17. I understand that violation of any of these rules may result in discontinuing my opioid medication. Without opioid medication I will experience withdrawal symptoms. If the treatment plan does not result in improvements, it may be discontinued.
18. I authorize my provider to cooperate fully with any city, state, or federal enforcement agency in the investigation of any possible misuse or sale of pain medication, hereby waiving my right to confidentiality in that event. I further authorize my providers to communicate with my family members, law enforcement, other health care providers about me and my treatment plan. This includes seeking my family members’ opinions about my level of function.

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Risks of Opioid Treatment

1. Physical dependence. This means that abruptly stopping the drug may result in withdrawal symptoms such as runny nose, diarrhea, abdominal cramps, goose bumps, and anxiety.
2. Psychological dependence. This means that stopping the drug may cause you to miss it or crave it.
3. Tolerance. This means that you need more and more of the drug to get the same effect.
4. Constipation. Inform your health care provider if this occurs so that the appropriate medications for constipation can be started promptly.
5. Increased sleepiness or drowsiness. If present, this side effect tends to decrease with continued use.
6. Problems with coordination, balance, or reflexes. This side effect can make it unsafe to operate dangerous equipment or motor vehicles. You should avoid these activities initially. Always use extra caution, especially until you have been on the medication long enough to know how it affects your ability to perform these activities. If there is any question about your abilities to safely perform any task, do not do it.
7. Addiction is a terrible and not infrequent consequence of opioid treatment. Please read carefully the paragraphs below.
8. This is not a comprehensive list; you should read the pharmacy information with your prescription. If you have questions, do not hesitate to ask at your next appointment.

Abuse of opioids is an unacceptable behavior. Addiction to opioids is a complication of treatment which happens to some people taking opioids. It is an inordinate craving of the medication without any consideration of its therapeutic effect or the bad effects on the person. Examples of behaviors that may indicate addiction include the following:

1. Taking larger doses of the opioid or taking opioid doses more frequently than prescribed.
2. “Losing” your prescriptions or medication. There will be no allowance for lost prescriptions or drugs. Prescriptions will not be refilled early to replace “lost” medication. It is important that you keep your medication secure at all times.

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3. “Stolen” prescriptions or medication. Your health care provider will not replace “stolen” prescriptions or medication. It is important that you keep your medication secure at all times.
4. Obtaining opioids from other sources not authorized by your health care provider.
5. Concurrent use of alcohol, tobacco, or illicit drugs.

Signature Page Follows

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I have read and understood the Interventional Pain Care LLC opioid policy. I realize opioid therapy has risks that must be accepted, and I accept those risks and all possible consequences.

I understand that failure to adhere to treatment may result in my dismissal from this practice's care. I may experience withdrawal symptoms which are likely to be very uncomfortable.

Name

Date

The above patient has demonstrated an understanding of the policy.

Name

Date