

AGREEMENT ON CONTROLLED SUBSTANCES THERAPY FOR CHRONIC PAIN TREATMENT

The purpose of this agreement is to inform you about medications for pain management and to assure that you and your physician comply with all state and federal regulations concerning the prescribing of controlled substances. A trial of opioid therapy can be considered for moderate to severe pain with the intent of reducing pain and increasing function. The physician's goal is for you to have the best quality of life possible given your clinical condition. Success of treatment depends on mutual trust and honesty in the physician/patient relationship and full agreement and understanding of the risks and benefits of using opioids to treat pain. The medical use of these medications is associated with the risk of serious adverse effects such as development of addiction or relapse. The proper dose is the lowest possible that is reasonably effective in managing pain and improving function.

1. **You must use only one physician to prescribe and monitor all opioid medications and adjunctive analgesics.** Exceptions may be made for situations such as surgery, emergency room, or dental procedures. Please inform our office of any planned surgeries or procedures.

2. You **must** inform your physician of **all medications** you are taking, including herbal remedies, since opioid medications can interact with over-the-counter medications and other medications prescribed or not, for example cough syrup that contains alcohol, codeine, or hydrocodone.

3. You must be seen on a regular basis and given prescriptions for enough medication to last from appointment to appointment, plus usually one or two days extra. Extra medication is **not** to be used without the explicit permission of the prescribing physician unless an emergency requires your appointment to be deferred.

4. Prescriptions for pain medicine or any other prescriptions will be provided only during an office visit or during regular office hours. **No refills of any medications will be provided during the evening or on weekends.**

5. If requested, you must bring back all opioid medications and adjunctive medications prescribed by your physician in the original bottles.

6. You are responsible for keeping your pain medication in a safe and secure place, such as a locked cabinet or safe. You are expected to protect your medications from loss or theft. Theft of medications must be reported to the police and to your physician immediately. **If your medications are lost, misplaced or stolen, your physician may choose not to replace them or to taper and discontinue them.**

7. **You may not give or sell your medications to any other person** under any circumstances. If you do, you may endanger that person's health. It is also against the law.

8. Any evidence of drug hoarding, acquisition of any opioid medication or adjunctive analgesics from other physicians, uncontrolled dose escalation, loss of prescriptions, or failure to follow this agreement **may result in termination of the doctor/patient relationship.**

9. You will communicate fully to your physician, at the initial and all follow-up visits, your pain level, functional status, and any side effects of the medications. This information allows your physician to adjust your treatment plan accordingly.

10. **You agree not to use any illicit substances, such as cocaine, heroin, methamphetamine, etc. while taking these medications.** Evidence of such use will result in a change to your treatment plan, such as safe **discontinuation of your opioid medications** when applicable, or **possible termination of the doctor/patient relationship.**

11. If you use or plan to use **"medical marijuana"**, you must inform your physician. Be aware THC will show up in body fluid testing (UTD and oral swabs).

12. I attest that I understand the risks of opioid therapy and the increased risks when used with **alcohol and/or benzodiazepines** (Ativan, Valium, Xanax, etc.)

13. You agree and understand that your physician will perform random or unannounced **urine or saliva drug testing.** If requested to provide a sample, you agree to cooperate. If you decide not to provide a sample, your doctor may change your treatment plan and may discontinue your opioid medications or terminate the doctor/patient relationship. The presence of a non-prescribed drug or illicit drug in the urine or oral swab, can be grounds for termination of the doctor/patient relationship. Such drug testing is done for our mutual benefit as a diagnostic tool and in accordance with legal and regulatory guidelines on the use of controlled substances to treat pain.

14. **Side effects** with opioid therapy may include skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation, hormonal abnormalities, and impaired cognitive (mental status) and/or motor ability. Overuse of opioids can cause decreased respiration (breathing) and even death, especially if other sedating medications are used (alcohol or tranquilizers). You should consider obtaining a naloxone kit for use in case of an emergency overdose.

15. If you have a **history of alcohol or drug misuse/addiction**, you must notify the physician, since treatment with opioids for pain may increase the possibility of relapse. A history of addiction does not, in most instances, disqualify one for opioid treatment of pain, but starting or continuing a program for recovery is a must.

16. Physical dependence and/or tolerance often occurs with the use of opioid medications. **Physical dependence** means that if opioid medication is abruptly stopped or not taken as directed, a withdrawal syndrome can occur. This is a normal physiological response. The **withdrawal** syndrome may include sweating, nervousness, abdominal cramps, diarrhea, goose bumps, and alterations in mood. Physical dependence does not equal addiction. **Addiction** is a primary, chronic neurobiologic disease with genetic, psychosocial and environmental factors influencing its development and manifestation, characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and cravings. This means the drug decreases one's quality of life. **Tolerance** is a state of adaptation in which exposure to the drug induces changes that result in decreased drug effectiveness over time. There is also a phenomenon called **opioid-induced hyperalgesia**, when opioids paradoxically increase pain sensitivity. Opioid doses may have to be titrated up or down to determine the dose that produces maximum function and a realistic decrease of pain.

17. The standard of care of medical pain management has been changing, such that opioids are becoming progressively less available to patients with "non-malignant" pain. Therefore, we seek to **minimize opioid dosages and to maximize use of non-opioid approaches to pain management**. You agree to cooperate with our efforts to manage your pain with the least amount of opioids possible along with non-opioid medications and non-medicinal treatments (THC, CBD, acupuncture, massage, meditation, yoga, chiropractic, physical therapy, etc).

18. You agree to allow your physician to contact any health care professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about your care or actions if the physician feels it is necessary.

19. You agree to a family conference or a conference with a close friend or significant other if the physician feels it is necessary.

20. You agree to participate in psychological evaluation and/or treatment with a psychologist or psychiatrist if your physician feels it is necessary.

21. I understand that due to the "opioid crisis" around misuse and abuse, opioids are becoming less available. Therefore, we will be offering training in non-medicinal treatments. Please see other form in this regard.

22. **Our office is typically open Tuesday, Wednesday, and Thursday (9AM to 4PM, and closed for lunch between 12PM to 1PM)**. We do our best to monitor the voicemails and email on nonclinical days, but cannot guarantee a response until the next business day. In addition, you understand that email is not HIPPA compliant, and we cannot guarantee the security of email messages.

23. You understand and agree that **failure to adhere to these policies** will be considered noncompliance and may result in cessation of opioid prescribing by your physician and possible dismissal from this clinic.

*These agreements have been explained to me by **Franklin Perry, M.D., Ph.D.** I affirm that I have been given the opportunity to ask any questions I may have. I agree to its terms so that **Dr. Perry** can provide quality pain management using opioid and other therapies to decrease my pain, increase my function, and improve my quality of life.*

Patient's Name: _____

Patient's Signature _____

Date _____

Physician's Signature _____

Date _____