OPIOID TREATMENT AGREEMENT

Patient Name (Print): _____

Prescriber Name (Print): _____

Medical Condition requiring Opioid: _____

Planned Opioid Medication: _____

I (patient) understand the following (initial each):

_____ I understand this agreement applies to opioid medications. Some of the common examples include but are not limited to oxycodone (e.g., Percocet), hydrocodone (e.g., Vicodin, Lortab), Hydromorphone (Dilaudid), morphine, fentanyl (e.g., Actiq), codeine (e.g., Tylenol with codeine), methadone, tramadol (e.g., Ultram), and buprenorphine (Suboxone or Subutex).

_____ I understand that opioids are prescribed to see if they increase my function including my ability to work, perform household chores, or otherwise regain activities.

_____ I understand that opioids are only one part of my treatment program.

_____ I understand that opioids may slightly reduce pain levels. Most studies report this as approximately 1/10, or in other words, from a pain level of "6 out of 10" to "5 out of 10." Opioids will **NOT** eliminate chronic pain and are unlikely to produce major improvements in pain.

_____ I understand that opioid medications have all of the following reported adverse effects (see Table 1a). Many, but not all of these risks increase with higher doses.

_____ I have had an opportunity to discuss these risks with my prescriber. I accept these risks.

Table 1a. Adverse Opioid Effects by Organ System

System	Effect	Secondary Effect
Cardiovascular	Myocardial infarction	Heart attack
	Orthostatic hypotension (dizziness on standing up)	Fainting on standing up
	Abnormal heart rhythm (QT prolongation)	Sudden death
Gastrointestinal	Gastroparesis (slow gut movement)	Nausea, weight loss
	Reduced colon motility; spasm	Constipation, bowel obstruction
	Biliary spasm	Stomach pain
Genitourinary	Exacerbation of prostate problems	Urinary retention
Endocrine	Suppression of testosterone	Impotence or reduced sex drive and erectile dysfunction, osteoporosis, feminization, reduced muscle mass, reduced strength
	Suppression of LH, FSH	Abnormal menstrual periods
	Adrenal suppression	Fatigue, low blood pressure, electrolyte changes
Immune	Tumor spread	Hastening of death if cancer is present
	Allergic reactions to medication	Rash, shortness of breath, itchy skin, edema
Neurological/ Psychiatric	Impairment of thinking or executive function	Outbursts, inappropriate behavior, limit testing, violence, reduced impulse control
	Frontal lobe atrophy	Alterations in executive function, emotional

		response
	Brain damage from overdose or apnea induced hypoxia	Slight to severe impairments if an overdose occurs
	Cognitive impairment	Problems thinking clearly
	Increased CNS pressure	Headache
	Hyperalgesia	Increased pain sensitivity, increasing doses of opioids/dose escalation
	Altered sense of taste	Reduced pleasure in eating, weight loss
	Reduced seizure threshold	Seizures
	Confusion, Impaired concentration	Increased accident risks and unclear thoughts
	Drowsiness, somnolence	Crash risk and reduced functioning
	Increased reaction time	Unsafe operation of machinery, motor vehicles, motor vehicle crashes
	Impaired coordination	Unsafe operation of machinery, falls
	Non-medical use	Overdose, death
	Mood elevation, euphoria	Mistaken judgment, changed interactions with other people
	Reduction in anxiety; tranquility	Mistaken judgment, changed interactions with other people
	Depression	Altered mood, depressed feelings, suicidal
Reproductive	Birth defects	Birth defects, miscarriage
	Neonatal withdrawal	Newborn babies of mothers on opioids go through opioid withdrawal
Respiratory	Respiratory depression	Death
	Central sleep apnea	Reduced ability to breath during sleep; daytime sleepiness; death
	Obstructive sleep apnea	New or increased problems with obstructive sleep apnea; daytime sleepiness; death
	Pneumonia	Pneumonia
	Hypoventilation	Worsening asthma and chronic obstructive pulmonary disease (COPD)
Vestibular	Reduced balance	Falls, fractures

_____ Opioids will be initially prescribed to me on a trial basis. The primary goal of this treatment is to improve my ability to perform various functions, including return to work, household chores or other physical or mental activities. If significant demonstrable improvement in my functional capabilities does not result from this trial, my prescriber will likely end the trial.

Goal for improved function: _____

_____ Opioids may also be prescribed to make my pain more tolerable, but these medications will not cause the pain to disappear entirely.

_____ Drowsiness and slowed reflexes may be temporary or ongoing adverse effects of opioids, especially during dosage adjustments. If I am experiencing drowsiness while taking opioids, I agree not to drive a vehicle or perform other tasks that could involve danger to myself, family members, coworkers, or others.

_____ Increased motor vehicle crashes have been reported in many studies among those taking opioids on a chronic basis. Especially for this reason, workers performing safety sensitive jobs (e.g., driving, operating heavy machinery, transporting goods or people, using overhead cranes, working at elevated heights, making complex judgments) are recommended to be precluded from performing safety sensitive jobs while taking opioids. If I am employed in a safety sensitive job, I will check with my employer to make sure this medication does not prevent me from working.

_____ Due to evidence of crashes and accidents among those taking opioids, I also agree to discuss whether I can drive my personal car and/or operate machinery at home with my provider.

_____ Using opioids to treat chronic pain will result in the development of a physical dependence on this medication, and sudden decreases or discontinuation of the medication will lead to symptoms of opioid withdrawal. These symptoms may include: nervousness, anxiety, difficulty sleeping, runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, vomiting, irritability, aches, and flu-like symptoms. I understand that opioid withdrawal is uncomfortable but not physically life threatening.

_____ There is a risk that opioid addiction may occur. This most commonly occurs in, but is not limited to, patients with a personal or family history of other drug or alcohol abuse. If my prescriber of opioids believes I may be developing addiction, I should expect that I will be taken off opioids.

I agree to the following (initial each):

_____ I agree to take the medication, _____(name) as prescribed. If problems arise, including adverse effects, I agree to promptly notify my prescriber.

_____ I agree to obtain opioids from **ONE** designated licensed prescriber.

_____ I agree to obtain opioids from **ONE** designated licensed pharmacist or pharmacy. By signing this agreement, I give consent to this provider to talk with the pharmacist.

_____ I agree to take the following non-opioid medication(s) as prescribed:

_____

_____

_____

_____ I agree to attend and fully participate in all appointments, treatments, examinations and consultations of my pain treatment which may be requested by my prescriber at any time.

_____ I agree to attend and fully participate in a regular exercise program if required. My specific exercise program is:

_____

_____.

_____ I agree to participate in fear avoidance belief training and/or cognitive behavior therapy if prescribed.

_____ I will participate fully in any psychiatric or psychological assessments if necessary.

_____ I agree to keep my scheduled appointments and/or cancel my appointment a minimum of 24 hours prior to the appointment. I agree to provide a reason for canceling any appointment.

_____ I understand that lack of improvements in function or a later loss of those functional benefit(s) are reasons that my prescriber may discontinue the opioid.

_____ I agree to **NOT** take more opioid medication than prescribed. I agree to **NOT** take doses of opioids more frequently than prescribed.

_____ I agree that in the event of an emergency potentially requiring pain medication, I will notify the emergency department or other treatment facility of this agreement. I will ask that this prescriber be contacted and the problem should be discussed with the emergency department or other treating provider. I agree that no

more than 3 days of medications may be prescribed by the emergency department or other provider without this provider's approval. If a situation arises in which I have no alternative but to obtain my necessary prescription from another prescriber (e.g., out of the country), I will then immediately advise my prescriber that I obtained a prescription from another prescriber.

_____ I agree to keep the opioid medication in a safe and secure place. I will keep all medications away from children.

_____ I understand that lost, damaged, or stolen medication will **NOT** be replaced.

_____ I agree to immediately report stolen opioid medication(s) to the police. My provider will also produce a police report if requested to do so.

_____ I agree not to share, sell, or in any way provide my medication to **ANY** other person.

_____ I agree to not use **ANY** other mood-modifying drugs, including alcohol (and marijuana if legal in my state), unless agreed to by my prescriber. Use of nicotine and caffeine are exceptions to this restriction.

_____ I agree to not use sedating over-the-counter medications, including diphenhydramine (e.g., Bendaryl).

_____ I agree to discuss any medication with a warning label that states it causes drowsiness or sleepiness with my prescriber prior to taking it.

_____ I agree to submit to unscheduled urine, blood, saliva, or hair drug testing at my prescriber's request, to verify my compliance.

_____ I agree that an abnormal urine, blood, saliva, or hair test will likely result in an end to the treatment with opioids. This includes a finding of a substance not expected (e.g., marijuana and/or illicit drugs).

_____ I understand that, if applicable, my prescriber may check my state's controlled substances database and/or Prescription Monitoring Database at any time to check my compliance.

_____ I agree to be seen by an addiction specialist if requested.

_____ I hereby agree that my provider has the authority to discuss my pain and opioid management with other health care professionals and my family members and/or significant others when it is deemed medically necessary in the provider's judgment. I agree to involve family and/or significant others in periodic assessments of my progress.

I have read this document. I understand it and have had all my questions answered satisfactorily. I consent to the use of opioids to improve my functioning through hopefully controlling my pain. I understand that my treatment with opioids will be carried out as described above. I understand that ANY deviation(s) from the above agreement are grounds for my prescriber to stop prescribing opioids at any time.

_____ _____
Patient Signature Date

_____ _____
Prescriber Signature Date

Adapted from the Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain, Utah Department of Health, 2009; U.S. Veterans Affairs Administration, Clinical Practice Guideline: Management of Opioid Therapy for Chronic Pain, 2010; and Washington State Department of Labor & Industries, Washington Agency Medical Directors' Group, Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain: An educational aid to improve care and safety with opioid therapy, 2010 Update.