How-to Guide

Opioid & Opioid Combination Medications Medical Policy Non-Network & Out-of-State Providers
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How-to Guide for Opioid & Opioid Combination Medications Medical Policy

Our state and our nation are facing an epidemic of opioid misuse, addiction and overdose. This epidemic is an urgent health crisis resulting from many years of over-prescribing and misunderstanding of the significant health risks these medications pose. In 2016, Blue Cross & Blue Shield of Mississippi (BCBSMS) partnered with our Network Providers including pain management experts, addiction experts and pharmacists to explore how we can do our part to address this public health crisis.

On March 1, 2017, BCBSMS is implementing the CDC Guideline for Prescribing Opioids for Chronic Pain through a comprehensive approach to ensure evidence-based, safe, responsible opioid prescribing for our members. This approach includes care management for those needing chronic pain management, enhanced patient education on the benefits and risks of taking opioids and a medical policy to reinforce safe prescribing. The goal is to provide medically necessary pain care, while reducing the risk of addiction and the unauthorized transfer of opioid prescriptions.

The Opioid and Opioid Combination Medications Medical Policy supports best practice treatment guidelines and includes limitations on drug usage and requires prior authorization as noted below:

<table>
<thead>
<tr>
<th>Medication or Class</th>
<th>Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short-acting Opioids</td>
<td>Coverage limited to 7-day supply of (&lt;50 \text{ MME/day for initial prescription. Coverage available for one additional 7-day supply within 60 days of initial fill.} )</td>
</tr>
<tr>
<td></td>
<td>Prior Authorization required for subsequent prescriptions. (\text{(Excludes cancer patients and those receiving end-of-life care.)})</td>
</tr>
<tr>
<td>Long-acting Opioids</td>
<td>Prior authorization required. (\text{(Excludes cancer patients and those receiving end-of-life care.)})</td>
</tr>
<tr>
<td>Opioids with Acetaminophen</td>
<td>Limited to 3 grams/day of acetaminophen.</td>
</tr>
</tbody>
</table>

This How-to Guide is intended to provide Providers and their office staff with a practical overview of various patient scenarios. The guide includes instructions which outline the step-by-step process for efficiently submitting Opioid Prior Authorization requests, where required. The guide also includes roles and responsibilities that have been established for Providers and their patients to safely manage opioid prescriptions.

Roles and Responsibilities

Providers

- Follow the Opioid and Opioid Combination Medications Medical Policy Guidelines.
- Prescribe alternative treatments, where appropriate, based on best practice treatment guidelines.
- Educate the patient regarding the benefits and risks of taking opioid pain medication.
- When required, submit the required Prior Authorization form online via [www.bcbsms.com](http://www.bcbsms.com).
This prior authorization process will facilitate a healthy provider-patient conversation by requiring:

- An active treatment plan that includes a specific treatment objective, duration of therapy and the use of other pharmacological and non-pharmacological agents for pain relief;
- A patient-signed informed consent document (see sample form);
- An addiction risk assessment (see sample form);
- A written/signed agreement between provider and patient (see sample form) addressing issues of prescription management, diversion and the use of other substances including but not limited to benzodiazepines, alcohol and sedatives; and
- Certification from the Provider that he or she is the single designated Provider, and a single designated Community PLUS Pharmacy has been agreed upon by the Provider and the patient.

Monitor your email to confirm the status of the Prior Authorization.

Monitor your email to ensure timely submission of additional information if requested.

Perform regular visits based on treatment plan agreed to with patient.

Patients

- Try alternative therapies as recommended by their Provider before taking opioids;
- Talk with their Provider about the risks of taking opioids and how to minimize the dangers;
- Safe, responsible prescribing of opioids based on CDC guidelines
  - Receiving no more than a 7-day supply of short-acting opioids with one 7-day refill, if needed.
  - Working with their Provider to complete our Opioid Prior Authorization process that serves as a practical guide to best-practice opioid prescribing when a long-acting opioid (or short-acting opioid beyond the quantity limit) is medically necessary.
- Agree to using one designated Provider and one designated Community PLUS Pharmacy location for opioid prescription fills.

When alternative treatment methods have failed and you prescribe an opioid for your patient, you may use the following chart to guide you in managing opioid prescriptions. Please refer to the following examples to help you and your office staff understand the practical approach for ensuring compliance with the Opioid and Opioid Combination Medications Medical Policy and any related prior authorizations.
For the purpose of this medical policy, chronic is defined as a diagnosis of migraine, fibromyalgia, osteoarthritis, low back/neck pain and neuropathic pain. The pain and opioid dependence transition period is determined based on the diagnosis on the claim.
For the purpose of this medical policy, chronic is defined as a diagnosis of migraine, fibromyalgia, osteoarthritis, low back/neck pain and neuropathic pain.

The following pages of this guide contain additional resources to assist you:

- Clinical Best Practice Guidelines for Common Pain Conditions
- Opioid Prior Authorization Process
- Sample Supporting Authorization Forms
  - Opioid Risk Tool
  - Patient Agreement Forms

<table>
<thead>
<tr>
<th>Patient Scenario</th>
<th>Prior Approval</th>
<th>Quantity Limit</th>
<th>Refill Allowed</th>
<th>Documented Treatment Failure with Short Acting Opioid in Past 60 Days</th>
<th>Treatment Plan</th>
<th>Informed Consent &amp; Substance Use Disorder Assessment</th>
<th>Certification from Provider for Single Prescriber and Single Community Plus Pharmacy Agreed on with Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient has a Cancer Diagnosis</td>
<td>NO</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>May be in Case Management</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>Patient is in Hospice/End of Life Care</td>
<td>NO</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>May be in Case Management</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>Patient needs initial prescription for long-acting opioid*</td>
<td>Prior Approval required beginning March 1, 2017.</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>*Refer to best practice guidelines for common pain conditions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient needs continued long-acting opioid prescription for a condition other than chronic condition</td>
<td>Prior Approval required beginning April 1, 2017.</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Patient needs continued long-acting opioid prescription for a chronic condition</td>
<td>Prior Approval required beginning June 1, 2017.</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
</tbody>
</table>
DESCRIPTION

All physicians should become knowledgeable about assessing patients’ pain and effective methods of pain treatment. This document provides evidence-based clinical best practice guidelines for management of common pain conditions.

Pain should be assessed and its cause diagnosed as clearly as possible using history and physical examination and appropriate testing. The medical management of pain should consider current clinical knowledge and medical research and the use of pharmacologic and non-pharmacologic modalities according to the judgment of the Provider. Pain should be promptly treated with non-pharmacologic therapy and non-opioid pharmacologic therapy, without acceptable results before opioids are considered.

Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release/short-acting opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than 7 days will rarely be needed. In addition, opioids are not the first-line therapy for chronic pain outside of active cancer treatment, palliative care, and end-of-life care. Evidence suggests that non-opioid treatments, including non-opioid medications and non-pharmacological therapies can provide relief to those suffering from chronic pain, and are safer.

Evidence-based clinical decision support is provided for the following acute pain conditions:
1. Headache
2. Back/Neck Pain Due to Strain or Sprain (Non-Radicular)
3. Mild-to-Moderate Radicular Back/Neck Pain
4. Severe Radicular Back/Neck Pain

Evidence-based clinical decision support is provided for the following chronic pain conditions:
1. Migraine (Vascular Headaches)
2. Osteoarthritis
3. Fibromyalgia
4. Carpel Tunnel Syndrome (Neuropathic Pain)
CLINICAL BEST PRACTICE GUIDELINES FOR COMMON ACUTE PAIN CONDITIONS

Headache

Initial Treatment:
1. NSAIDS
2. Acetaminophen
3. Combination of caffeine with simple analgesics
4. Anti-emetics
5. Non-pharmacologic treatment (heat/ice/massage/rest)

Opioids should not be used

If Unresponsive to Initial Treatment:
1. Evaluate for co-morbidities
2. Consider specialist referral

Preventive:
1. Non-pharmacologic treatment (heat/ice/massage/rest)
2. Stress reduction
3. Good sleep hygiene

Back/Neck Pain Due to Strain or Sprain (Non-Radicular)

Initial Treatment:
1. NSAIDS
2. Acetaminophen
3. Combination of muscle relaxants with simple analgesics
4. Physical therapy
5. Chiropractic therapy
6. TENS Unit
7. Non-pharmacologic treatment (heat/ice/massage/rest)

Short-acting low potency opioids may be used if pain lasts at least 2 weeks and non-responsive to simple analgesics/muscle relaxants - limit to 2 week supply

If Unresponsive to Initial Treatment:
1. Evaluate for co-morbidities
2. Consider specialist referral

Preventive:
1. Non-pharmacologic treatment (heat/ice/massage/rest)
2. Exercise
3. Stress reduction
4. Good sleep hygiene
Mild-to-Moderate Radicular Back/Neck Pain (Pain Rating of 1-6/10 on Universal Pain Assessment Tool)

**Initial Treatment:**
1. NSAIDS
2. Acetaminophen
3. Activity modification to lessen nerve root impingement
4. Combination of muscle relaxants with simple analgesics
5. Physical therapy
6. Consider oral glucocorticoids
7. Non-pharmacologic treatment (heat/ice)

**Opioids should not be used**

**Short-acting low potency opioids may be used** if there is a significant renal, gastric, or cardiovascular risk for NSAIDS use or hepatic risk for acetaminophen use - limit to 2 week supply

**If Unresponsive to Initial Treatment:**
1. Evaluate for co-morbidities
2. Consider specialist referral (surgery, pain management for epidural glucocorticoids)
Severe Radicular Back/Neck Pain (Pain Rating of 7-10/10 on Universal Pain Assessment Tool)

Initial Treatment:
1. NSAIDS
2. Acetaminophen
3. Activity modification to lessen nerve root impingement
4. Combination of muscle relaxants with simple analgesics
5. Physical therapy
6. Consider oral glucocorticoids
7. Non-pharmacologic treatment (heat/ice)

If Unresponsive to Initial Treatment:
1. Evaluate for co-morbidities
2. Specialist referral (surgery, pain management for epidural glucocorticoids)

Short-acting low potency opioids may be used - limit to 2 week supply
CLINICAL BEST PRACTICE GUIDELINES FOR COMMON CHRONIC PAIN CONDITIONS

**Migraine**

**Initial Treatment:**
1. NSAIDS
2. Acetaminophen
3. Triptans
4. Anti-emetics
5. Ergots

**Opioids** should not be used, except as a last resort (short-acting low potency)

**Preventive:**
1. Beta blocker
2. Anti-seizure medication
3. Antidepressant medication
4. Consider specialist referral for OnabotulinumtoxinA

**Osteoarthritis**

**Initial Treatment:**
1. NSAIDS
2. Prescription/OTC Topical NSAIDS
3. Topical capsaicin
4. Intra articular glucocorticoids
5. Non-pharmacologic treatment (exercise, counseling regarding weight loss, patient education)

**If Unresponsive to Initial Treatment:**
Referral to specialists (i.e. rheumatologist, physiatrist, orthopedic surgeon, pain management)

**Short-acting low potency opioids** if still unresponsive to treatment AND not a surgical candidate

**Preventive:**
Non-pharmacologic treatment (exercise, counseling regarding weight loss, patient education)
Fibromyalgia

**Initial Treatment:**
1. Patient Education
2. Exercise
3. Good sleep hygiene
4. Tricyclic antidepressants
5. Cyclobenzaprine
6. Serotonin–norepinephrine reuptake inhibitors
7. Gabapentin

If Unresponsive to Initial Treatment:
1. Physical therapy
2. Referral to specialists (i.e. rheumatologist, physiatrist, sleep specialist, psychiatrist, pain management)

Carpel Tunnel Syndrome (Neuropathic Pain)

**Initial Treatment:**
1. Wrist splitting
2. Glucocorticoid injection
3. Oral glucocorticoids
4. Occupational therapy

If Unresponsive to Initial Treatment:
1. Physical therapy
2. Referral for Surgical Evaluation

Opioids should not be used
POLICY HISTORY
02/20/2017: Guidelines approved by Pain Management Physician Advisory Committee

SOURCES


2. Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline From the American College of Physicians. Amir Qaseem, MD, PhD, MHA; Timothy J. Wilt, MD, MPH; Robert M. McLean, MD; Mary Ann Forciea, MD. Annals of Internal Medicine. February 14, 2017.

3. Treatment of low back pain. UpToDate®. Christopher L Knight, MD; Richard A Deyo, MD, MPH; Thomas O Staiger, MD; Joyce E Wipf, MD. December 21, 2016 https://www.uptodate.com/contents/treatment-of-acute-low-back-pain?source=search_result&search=treatment%20of%20acute%20back%20pain&selectedTitle=2~150


5. Acute lumbosacral radiculopathy: Treatment and prognosis. UpToDate®. Kerry Levin, MD; Philip S Hsu, MD; Carmel Armon, MD, MHS. November 9, 2016. https://www.uptodate.com/contents/acute-lumbosacral-radiculopathy-treatment-and-prognosis?source=search_result&search=acute%20lumbosacral%20radiculopathy&selectedTitle=1~150


Opioid Prior Authorization Process for Non-Network and Out-of-State Providers
A step-by-step guide to assist your staff in completing the electronic prior authorization process for opioid medication.


2. Navigate to the I’m a Provider menu and click on the Provider Information link.
3. Next you will see the Out of Area and Non-Network Provider Prior Authorization Process Links section. The Submit a Prescription Drug Prior Authorization Request link will be found here.
4. Next you will be prompted to type in the BCBSMS Member ID and Prescribing Provider NPI. Once you enter the Member ID, select “Get Member Info.” You must click the dropdown arrow to ensure you select the correct patient name if there are multiple patients listed on the benefit plan.

Enter the Prescribing NPI and select “Get Provider Info,” then click the dropdown to review the provider information.

5. The patient’s information will automatically populate once the patient is selected.
6. The next step will be to select the drug name for the prescription the patient will be receiving.
7. Once the drug name has been selected, the next page will include Patient Information, Coverage Information, Prescriber Information and Guiding Documentation/Instructions. There are fields that are auto-populated based on the Patient and Prescriber. All of the questions must be thoroughly answered to ensure the medical information is properly documented. The Opioid and Opioid Combinations section requires you to enter information on the diagnosis, medical justification and prescription. Additional information can be placed in the Additional Explanation field.
Some of the questions will require additional documentation to complete the prior authorization request. Documentation can be submitted through document upload or faxed once the Opioid Prior Authorization form has been submitted.
8. Once all of the information has been entered, a confirmation message will be displayed that presents options to upload more information or to print the fax cover sheet if supplemental documentation will be faxed.

If the “submit attachments needed to accompany this request” option is selected, the following box will display:
First, Choose the Upload option. Second, click the “Browse” button to select the corresponding file that will be uploaded.

Once the corresponding file has been selected, click the ‘Open’ button to return to the upload box. This will save the document to that specific question.

If the “print a cover sheet in order to fax attachments needed to accompany this request” option is selected, this box will appear:
Click on the “Print Fax Cover Sheet” option to upload the fax cover sheet. The fax cover sheet has a bar code that identifies the specified prior authorization request; therefore, it is unique to the request and **MUST be attached to the documentation as the first page of the fax** for the information to be processed correctly. If the fax cover sheet is not the first page transmitted, the information will not be processed.

The following is an example of an “Electronic Pre-Certification/Prior Authorization” fax cover sheet:

Once the prior authorization and supporting documentation have been submitted it is important to monitor the email that was entered into the request daily for additional correspondence and for prior authorization determination from the BCBSMS.

All communication regarding the status of the prior authorization will be handled via email. It is very important that you check this email daily to determine if your request was approved, denied, or if additional information is requested. The notification will have additional notes explaining the decision that was made. Please read these notes carefully to ensure any additional documentation requested is submitted to properly process the prior authorization request.
If you have questions regarding the prior authorization process, please contact our Provider Service Call Center at 601-932-1122 or 1-800-257-5825, 8:00 a.m. to 4:30 p.m., Monday through Friday.

Below, you will find the following sample supporting documents:

- **Opioid Risk Tool**
- **Sample Patient Agreement Forms** - The sample forms attached here contain language that makes these agreements meet both of the following prior authorization criteria:
  - A patient-signed informed consent document
  - A written/signed agreement between provider and patient addressing issues of prescription management, diversion and the use of other substances including but not limited to benzodiazepines, alcohol and sedatives

These forms can be used to assist you in your conversations and assessments with your patients. Completed forms may be submitted as the supporting documents for the prior authorization.
Opioid Risk Tool

Introduction

The Opioid Risk Tool (ORT) is a brief, self-report screening tool designed for use with adult patients in primary care settings to assess risk for opioid abuse among individuals prescribed opioids for treatment of chronic pain. Patients categorized as high-risk are at increased likelihood of future abusive drug-related behavior. The ORT can be administered and scored in less than 1 minute and has been validated in both male and female patients, but not in non-pain populations.

http://www.drugabuse.gov/nidamed-medical-health-professionals
Opioid Risk Tool

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

<table>
<thead>
<tr>
<th>Mark each box that applies</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family history of substance abuse</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Illegal drugs</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Rx drugs</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td><strong>Personal history of substance abuse</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Illegal drugs</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Rx drugs</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td><strong>Age between 16—45 years</strong></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>History of preadolescent sexual abuse</strong></td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td><strong>Psychological disease</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADD, OCD, bipolar, schizophrenia</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Depression</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Questionnaire developed by Lynn R. Webster, MD to assess risk of opioid addiction.

Sample Patient Agreement Forms

Introduction
This resource includes two sample patient agreement forms that can be used with patients who are beginning long-term treatment with opioid analgesics or other controlled substances. These documents contain statements to help ensure patients understand their role and responsibilities regarding their treatment (e.g., how to obtain refills, conditions of medication use), the conditions under which their treatment may be terminated, and the responsibilities of the health care provider. These documents can help facilitate communication between patients and healthcare providers and resolve any questions or concerns before initiation of long-term treatment with a controlled substance.

http://www.drugabuse.gov/nidamed-medical-health-professionals
Pain Treatment with Opioid Medications: Patient Agreement*

I, ____________________________, understand and voluntarily agree that (initial each statement after reviewing):

_____ I will keep (and be on time for) all my scheduled appointments with the doctor and other members of the treatment team.

_____ I will participate in all other types of treatment that I am asked to participate in.

_____ I will keep the medicine safe, secure and out of the reach of children. If the medicine is lost or stolen, I understand it will not be replaced until my next appointment, and may not be replaced at all.

_____ I will take my medication as instructed and not change the way I take it without first talking to the doctor or other member of the treatment team.

_____ 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 with the treatment team.

_____ I will make sure I have an appointment for refills. If I am having trouble making an appointment, I will tell a member of the treatment team immediately.

_____ I will treat the staff at the office respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped.

_____ I will not sell this medicine or share it with others. I understand that if I do, my treatment will be stopped.

_____ I will sign a release form to let the doctor speak to all other doctors or providers that I see.

_____ I will tell the doctor all other medicines that I take, and let him/her know right away if I have a prescription for a new medicine.

_____ I will use only one pharmacy to get all on my medicines: __________________________

______ I will not get any opioid pain medicines or other medicines that can be addictive such as benzodiazepines (klonopin, xanax, valium) or stimulants (ritalin, amphetamine) without telling a member of the treatment team before I fill that prescription. I understand that the only exception to this is if I need pain medicine for an emergency at night or on the weekends.

*Adapted from the American Academy of Pain Medicine
I will not use illegal drugs such as heroin, cocaine, marijuana, or amphetamines. I understand that if I do, my treatment may be stopped.

I will come in for drug testing and counting of my pills within 24 hours of being called. I understand that I must make sure the office has current contact information in order to reach me, and that any missed tests will be considered positive for drugs.

I will keep up to date with any bills from the office and tell the doctor or member of the treatment team immediately if I lose my insurance or can't pay for treatment anymore.

I understand that I may lose my right to treatment in this office if I break any part of this agreement.

**Pain Treatment Program Statement**

We here at ________________ are making a commitment to work with you in your efforts to get better. To help you in this work, we agree that:

We will help you schedule 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 this treatment is as safe as possible. We will check regularly to make sure you are not having bad side effects.

We will keep track of your prescriptions and test for drug use regularly to help you feel like you are being monitored well.

We will help connect you with other forms of treatment to help you with your condition. We will help set treatment goals and monitor your progress in achieving those goals.

We will work with any other doctors or providers you are seeing so that they can treat you safely and effectively.

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.

Patient signature ___________________ Patient name printed ___________________ Date ___________________

Provider signature ___________________ Provider name printed ___________________ Date ___________________

*Adapted from the American Academy of Pain Medicine*  
Patient Agreement Form

Patient Name: ____________________________
Medical Record Number: ______________________
Addressograph Stamp: ________________________

AGREEMENT FOR LONG TERM CONTROLLED SUBSTANCE PRESCRIPTIONS

The use of ____________________________ (print names of medication(s)) may cause addiction and is only one part of the treatment for: ____________________________ (print name of condition—e.g., pain, anxiety, etc.).

The goals of this medicine are:
☐ to improve my ability to work and function at home.
☐ to help my ____________________________ (print name of condition—e.g., pain, anxiety, etc.) as much as possible without causing dangerous side effects.

I have been told that:
1. If I drink alcohol or use street drugs, I may not be able to think clearly and I could become sleepy and risk personal injury.
2. I may get addicted to this medicine.
3. If I or anyone in my family has a history of drug or alcohol problems, there is a higher chance of addiction.
4. If I need to stop this medicine, I must do it slowly or I may get very sick.

I agree to the following:
- I am responsible for my medicines. I will not share, sell, or trade my medicine. I will not take anyone else’s medicine.
- I will not increase my medicine until I speak with my doctor or nurse.
- My medicine may not be replaced if it is lost, stolen, or used up sooner than prescribed.
- 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 bring the pill bottles with any remaining pills of this medicine to each clinic visit.
- I agree to give a blood or urine sample, if asked, to test for drug use.

Refills

Refills will be made only during regular office hours—Monday through Friday, 8:00AM-4:30 PM. No refills on nights, holidays, or weekends. I must call at least three (3) working days ahead (M-F) to ask for a refill of my medicine. No exceptions will be made. I will not come to Primary Care for my refill until I am called by the nurse.

I must keep track of my medications. No early or emergency refills may be made.

Pharmacy

I will only use one pharmacy to get my medicine. My doctor may talk with the pharmacist about my medicines. The name of my pharmacy is _____________________________.

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Prescriptions from Other Doctors

If I see another doctor who gives me a controlled substance medicine (for example, a dentist, a doctor from the Emergency Room or another hospital, etc.) I must bring this medicine to Primary Care in the original bottle, even if there are no pills left.

Privacy
While I am taking this medicine, my doctor may need to contact other doctors or family members to get information about my care and/or use of this medicine. I will be asked to sign a release at that time.

Termination of Agreement
If I break any of the rules, or if my doctor decides that this medicine is hurting me more than helping me, this medicine may be stopped by my doctor in a safe way.

I have talked about this agreement with my doctor and I understand the above rules.

Provider Responsibilities
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.

Patient’s signature _________________________ Date ____________

Resident Physician’s signature _________________________

Attending Physician’s signature _________________________

☐ This document has been discussed with and signed by the physician and patient. (A signed copy stamped with patient’s card should be sent to the medical records department and a copy given to the patient.)