**Controlled Substance Agreements**

Why should we use controlled substance agreements? What is in such an agreement? What would an agreement look like? We have provided all of this information here for your use.

The controlled substance agreement has often been looked at as a tool used only for those patients where abuse is suspected or thought to be occurring in prescribing. This has made it difficult for providers to hold trustful relationships with those patients. This practice needs to quickly change. Every patient who is prescribed a controlled substance should sign one of these agreements. This is not a contract. Instead, this is a joint agreement between the healthcare provider and patient that holds both the provider and the patient responsible for their actions. The provider and patient should read through the agreement together so each party understands the terms of the agreement. It is important to explain to each patient that this agreement is a standard of care and every patient who is prescribed a controlled substance is asked to read and sign it. Finally, be sure to follow up with your side of the agreement: check the controlled substance database, do urine drug screens, and always remember why you became a healthcare provider. This includes helping those who have a legitimate need for controlled substances and preventing others from becoming dependent and addicted.

The written agreement may include some/all of the following:

- Goals of therapy (including, but not limited to, physical, emotional, and social)
- A limitation on quantity and refills
- Responsibility of the patient to keep the medication safe and secure
- The routine use of urine drug screens
- An agreement to see only one healthcare provider/clinic
- Responsibility of the provider to educate patient on possible benefits and side effects (including addiction)
- The need for regular appointments and re-assessment
- Responsibility of the patient to take the medication as prescribed
- Responsibility of the provider to recognize if dependence/addiction is occurring and to take the appropriate steps for the benefit of the patient
- Consequences of breaking the agreement

# Controlled Substance Agreement

Reference: Adapted from ICSI Assessment and Management of Chronic Pain, Second Edition, March 2007. Accessed: https://www.communitycarenc.org/media/related-downloads/cpi-toolkit-pcps.pdf. January 9, 2013.

I understand that _____ (MD/FNP/PAC) is prescribing opioid medication to help me manage chronic pain that has not responded to other treatments. The goal of this medication is to lead to partial relief from pain, so that my physical, emotional, and social function will improve. If my activity level or general function gets worse, the opioid may be stopped or changed to something else. The risks, side effects and benefits of opioid treatment have been explained to me and I agree to the following instructions. Failure to follow these instructions may result in stopping the medication.

1.) I will participate in any other treatments recommended by my provider. I will be ready to decrease or stop the opioid medication when other effective treatments become available.

2.) I will take my medications exactly as prescribed and will not change the medication schedule or dosage without advance approval from my provider. I will provide my medication for pill/ film/ patch counts at the provider's request. I will not request early refills.

3.) I will keep regular appointments with my provider.

4.) All opioid and other controlled drugs for pain must be prescribed only by _____ .

5.) I will inform my provider within a week of discharge if I am hospitalized for any reason or if I have another condition that requires the prescription of a controlled drug (like narcotics, tranquilizers, barbiturates, or stimulants).

6.) I will choose one pharmacy where all of my prescriptions will be filled.

Pharmacy Name: _____

Phone Number: _____

Fax Number: _____

Address: _____

_____

_____

7.) I understand that lost or stolen prescriptions will not be replaced, so I will keep my prescription and medication in a safe place. I will not under any circumstance sell, lend, or give my medication to others.

8.) I agree to avoid all illegal and recreational drugs (including alcohol) and will provide urine or blood specimens at the provider's request to monitor my compliance.

9.) I agree to follow my provider's recommendations regarding the operation of motor vehicles or heavy machinery while taking this medication.

10.) Refills will be made only during regular office hours, which are _____. Refills will not be made at night, on weekends or during holidays. I am responsible for keeping track of my remaining medication, so I can call for refills in advance. This way, I will not run out of medication.

Name (print): _____

Patient Signature: _____ Date:_____

Provider Signature:_____ Date:_____

Witness (optional): _____ Date:_____

# Sample Opiate/Pain Management Agreement*

*Based on the Sample Opiate/Pain Management Agreement used by the Maine Office of Substance Abuse.*

The purpose of this Agreement is to prevent misunderstandings about certain medications you will be taking for pain management. This Agreement is to help you and your provider to comply with the law regarding controlled pharmaceuticals.

_____ I understand that there is a risk of psychological and/or physical dependence and addiction associated with chronic use of controlled substances.

_____ I understand that this Agreement is essential to the trust and confidence necessary in a provider/patient relationship and that my provider undertakes to treat me based on this Agreement.

_____ I understand that if I break this Agreement, my provider will stop prescribing these pain control medicines.

_____ In this case, my provider will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

_____ I would also be amenable to seek psychiatric treatment, psychotherapy, and/or psychological treatment if my provider deems necessary.

_____ I will communicate fully with my provider about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

_____ I will not use any illegal controlled substances, including marijuana, cocaine, etc., nor will I misuse or self-prescribe/medicate with legal controlled substances. Use of alcohol will be limited to times when I am not driving or operating machinery and will be infrequent.

_____ I will not share my medication with anyone.

_____ I will not attempt to obtain any controlled medications, including opioid pain medications, controlled stimulants, or anti-anxiety medications from any other provider.

_____ I will safeguard my pain medication from loss, theft, or unintentional use by others, including youth. Lost or stolen medications will not be replaced.

_____ I agree that refills of my prescriptions for pain medications will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.

_____ I agree to use this pharmacy _____ located at this address _____ with the telephone number of _____ for filling my prescriptions for all of my pain medicine.

_____ I authorize the provider and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication. I authorize my provider to provide a copy of this Agreement to my pharmacy, primary care provider and local emergency room. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

_____ I agree that I will submit to a blood or urine test if requested by my provider to determine my compliance with my program of pain control medications.

_____ I understand that my provider will be verifying that I am receiving controlled substances from only one prescriber and only one pharmacy by checking the Prescription Monitoring Program web site periodically throughout my treatment period.

_____ I agree that I will use my medicine at a rate no greater that the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.

_____ I will bring unused pain medicine to every office visit.

_____ I agree to follow these guidelines that have been fully explained to me.

All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This Agreement is entered into on this _____ day of _____, 201_.

Patient Signature: _____

Patient Name (printed):_____

Provider signature: _____

Provider Name (printed):_____

Witnessed by:
Signature: _____

Name (printed):_____