

Medication Contract

1. I, _____ agree that
Dr. _____ will be the only physician prescribing
_____ medication for me and that I will obtain all
of my prescriptions at one pharmacy. The exception would be an emergency situation or in the
unlikely event that I run out of medication. Should such occasions occur, I will inform my
physician as soon as possible.
2. I will take the medication at the dose and frequency prescribed by my physician. I agree not to
increase the dose without first discussing it with my physician.
3. I will attend all reasonable appointments, treatments and consultations as requested by my
physician.
4. I understand that using long-term medication may result in the development of a physical
dependence on this medication, and that sudden decreases or discontinuation of the medication
will lead to the symptoms of withdrawal.
5. I understand that there is a small risk that I may become addicted to the medication I am being
prescribed. As such, my physician may require that I have additional blood, urine or hair testing
and/or see a specialist in addiction medicine should a concern about addiction arise during my
treatment.
6. I understand that the use of any mood-modifying substance, such as, tranquilizers, sleeping pills,
alcohol or illicit drugs (such as cannabis, cocaine, heroin or hallucinogens), can cause adverse
effects or interfere with my therapy. Therefore I agree to refrain from the use of all of these
substances without prior agreement from my physician.
7. I agree to be responsible for the secure storage of my medication at all times. I agree not to give
or sell my prescribed medication to any other person. Depending on the circumstances, lost
medication may **NOT** be replaced until the next regular renewal date.
8. I consent to open communication between my doctor and any other health care professionals
involved in my pain management, such as pharmacists, other doctors, emergency departments,
etc.
9. I understand that if I break this agreement, my physician reserves the right to stop prescribing
these medications for me.

Date: _____

(Patient)

(Doctor)

Termination of opioid therapy

Date:

To:

Dear Patient:

Previously, you and I signed a written agreement regarding the treatment of your chronic pain problem with opioid therapy. There were certain conditions and goals of treatment to which you agreed.

I am sorry that you have chosen not to abide by one or more of the terms of this agreement. In my professional opinion, for your safety, it is now necessary to withdraw you from opioid therapy and try other forms of treatment for your chronic pain.

Opioid withdrawal symptoms are unpleasant but not life threatening. You may experience any or all of the following: sweats, chills, headaches, muscle aches, joint aches, abdominal cramps, nausea, vomiting diarrhea, anxiety, fatigue, malaise, "goose flesh". These symptoms are similar to a severe flu-like illness. They will begin within 12-36 hours of reducing the dose of your opioid medication, be most severe for 24-72 hours and then begin to fade away. Some people report feeling tired and mildly unwell for 1-2 weeks after completely stopping opioids. You should then feel the same as you were prior to beginning opioid therapy.

To try to minimize these withdrawal symptoms, I will taper your opioids over a 10-14 day time period. I will also suggest some medications you can take to decrease the withdrawal symptoms. I will provide your pharmacist with detailed instructions on how much and when to dispense your medication.

I can still offer to help you search for other treatments for your chronic pain. If you choose to see another physician I would be pleased to send a summary of my treatment to any physician of your choosing.

Should you wish to try opioid therapy again at some future date and are willing to comply with the terms of the agreement, I would be willing to reconsider your case.

_____, M.D.

A Sample Letter for the Pharmacist

Date:

Dear Pharmacist:

Re: _____

This patient suffers from chronic non-cancer pain which has not responded to standard treatments.

I have decided to prescribe a trial of scheduled long-term opioid therapy. As part of our therapeutic agreement, the patient has agreed to obtain all of his/her medications at one pharmacy only and to give the pharmacist permission to communicate freely with me regarding concerns about any prescriptions. The patient also agrees not to obtain and use any OTC products containing codeine while taking this form of therapy.

Since the patient has chosen you as their pharmacist, I would appreciate it if you would call me at your convenience to acknowledge receipt of this letter and to ask me any questions that you may have.

I will be starting this treatment plan by using some or all of the following medications in sequence and titrating them upwards on a weekly or q2 weekly basis:

(Check and initial those medications you plan to use and cross out and initial the others)

- acetaminophen with codeine 30mg (Tylenol#3) up to a maximum of 12 tabs per day*
- controlled release codeine (Codeine Contin) up to a maximum of 800mg per day*
- acetaminophen with oxycodone 5mg (Percocet) up to a maximum of 12 tabs per day*
- short acting oxycodone (Oxy-IR, Supeudol)*
- controlled release oxycodone (OxyContin)*
- short acting morphine (MS-IR, Statex)*
- sustained release morphine (MS Contin, M-Eslon, Kadian)*
- short acting hydromorphone (Dilaudid)*
- controlled release hydromorphone (Hydromorph Contin, Palladone XL)*
- transdermal fentanyl (Duragesic patch)*

If the patient complies with our agreement and the pain is well controlled on a stable dose of opioid, I will continue to renew prescriptions at intervals of no longer than two months.

Please advise me of any concerns that you may have regarding our mutual patient. I am especially interested in knowing if our patient does not appear to be using the medication as prescribed or is receiving prescriptions for any psychoactive medications from any other physician.

This letter automatically expires and needs to be renewed _____month(s) from the above date. Thank you for your case and interest.