INTERMED
Care without compromise.

Controlled Medication Agreement
Ages 13+

This agreement is between patient and physician/NPPA regarding the use of controlled medications in the following categories: **opioids, benzodiazepines, stimulants, buprenorphine**. This agreement is for patients with current or anticipated use of the previously mentioned medications for 90 or more days in a 12-month period.

I (patient): _____ Date of Birth: _____, have agreed to take the medication(s): _____. The physician/NPPA is prescribing this medication(s) for the diagnosis of: _____.

I agree to and understand the following:

When a parent or guardian is signing on behalf of a patient, the parent/guardian is expected to ensure the patient adheres to this agreement, to the best of his/her knowledge.

1. The risks and side effects associated with the use of controlled medications have been explained.
2. When clinically indicated, alternative medications that are not controlled medications and therapies, including their risks and benefits have been explained and offered.
3. All prescriptions for the above medication(s) must come from the physician/NPPA who signs this agreement or a covering practitioner unless authorization is obtained for an exception.
4. I will tell the physician/NPPA all medications and substances I am taking, including over the counter, herbal, and prescribed medications, as well as past and present use/misuse of alcohol and substances (illicit, recreational, street drugs, prescription).
5. I agree to take the medication as prescribed and will not change the dose or stop the medication without talking with the physician/NPPA during scheduled appointments.
6. I agree that this medication will be stopped if symptoms do not improve, the medication loses its effectiveness, required office appointments are not attended, if there is reason to believe the medication is being misused, or the physician/NPPA decides the treatment is not advisable.
7. I will make refill requests by phone or via the patient portal at least three business days before the refill is due. Refill requests will not be processed on nights, weekends, or holidays. I will not ask for early refills.
8. I will not request variations or exceptions to this agreement.
9. I will communicate respectfully with the InterMed team and understand that disrespectful interactions could be grounds for discharge from InterMed.
10. I will store this medication in a secure place. I will not share, sell, or otherwise dispense this medication to anyone else. Lost or misplaced prescriptions may not be replaced. If the medication is stolen, a copy of the police report must be given to the physician/NPPA for a replacement to be considered. Laws may not allow replacements.
11. I understand that at least annually I will have an appointment with the prescribing physician/NPPA to review the treatment plan and renew this agreement. Prescription renewals are based on keeping appointments and following prescription directions. If I need to cancel or reschedule, I will give the office at least 1 business days' notice.
12. I understand that InterMed will check the Maine Prescription Monitoring Program website as required by law, which tracks controlled medication prescriptions received from all prescribers.
13. I will not request controlled medications from other healthcare providers.
14. I will tell other healthcare providers I am taking this medication(s).
15. The physician/NPPA explained that alcohol and substance use are not recommended with this medication, and their use together can cause serious side effects, up to and including life-threatening reactions.

16. **Patients 65 years and older**: I understand I may have a higher risk of side effects, due to changes that naturally occur with aging.
17. **For patients who may become pregnant and/or are breastfeeding:**
    a. While on this medication(s), I should use safe and effective birth control. If I plan to become pregnant or believe I am pregnant while taking this medication, I will notify the physician/NPPA to discuss safe treatment options.
    b. If I am breastfeeding, I will discuss safe treatment options with the physician/NPPA.
18. The physician/NPPA or covering practitioner may ask for a drug screening and/or to count the medication(s). If InterMed requests a drug screening and/or medication count, InterMed will schedule a visit within two business days, which I will attend, and bring the prescription to that visit, if requested. Out-of-pocket costs for drug screenings will be my responsibility.
19. If substance use is suspected, I understand I may be asked to leave and may not be prescribed any medication at that time, and/or my physician/NPPA may recommend a different level of care, including services outside InterMed.
20. I authorize InterMed to share information about my care with other healthcare providers, pharmacies, insurers, and law enforcement, where deemed necessary by the physician/NPPA or as otherwise permitted or required by law.
21. I will notify InterMed of changes in my contact information.
22. I understand that the physician/NPPA may stop prescribing this medication(s) if:
    a. I am found to be using substances or medications, legally or illegally, that I did not tell the physician/NPPA about.
    b. I do not follow the treatment plan as recommended by the physician/NPPA.
    c. I do not fulfill any of the responsibilities in this agreement, which may also result in being discharged from care by the physician/NPPA or InterMed.
    d. I miss two consecutive appointments associated with the medication or related health condition(s).

Opioids ONLY:

1. I understand that state and/or federal laws and InterMed policies limit the amount of opioid medication I can receive and that InterMed physician/NPPAs are required to comply with those laws, regulations, and policies.
2. I am aware that chronic opioid use can cause low testosterone levels. This may affect mood, stamina, and sexual desire.
3. If I abruptly stop taking an opioid medication, I understand I may have withdrawal symptoms, that may require hospitalization.

Benzodiazepines ONLY: I understand I should not take Z-drugs [zolpidem (Ambien™), eszopiclone (Lunesta™), zaleplon (Sonata™)] while on a benzodiazepine medication because of risks, including death, caused by the effects on breathing.

Stimulants ONLY: I understand stimulants can significantly decrease appetite, and the physician/NPPA may monitor this.

Buprenorphine ONLY:

1. If I abruptly stop taking buprenorphine, I understand I could experience withdrawal symptoms, that may require hospitalization.
2. I agree to notify the physician/NPPA about any drug or substance use that may be defined as relapsing. I understand that this can be life-threatening, and a treatment plan must be developed as soon as possible.
3. I understand taking buprenorphine with benzodiazepines [Valium™ (diazepam), Klonopin™ (clonazepam), Ativan™ (lorazepam), etc.], other controlled medications, and/or alcohol can be dangerous and that deaths have been reported among persons mixing buprenorphine with benzodiazepines and/or alcohol.

I had an opportunity to read the above agreement or have had it read to me. I had my questions answered to my satisfaction. I understand and accept the risks and terms of the treatment as proposed. I am signing this form voluntarily, and I have full right and power to be bound by this agreement.

Patient/Guardian Signature: _____

If not signed by the patient, relationship to patient: _____ Date: _____

When a parent or guardian is signing on behalf of a patient, the parent/guardian is expected to ensure the patient adheres to this agreement, to the best of his/her knowledge.

Physician/NPPA Signature: _____ Date: _____

Printed Name of Physician/NPPA: _____

Cc: Primary Care Physician/NPPA (if different than above): _____