Alabama Medicaid Pharmacy
Opioid Dependence Treatment Agreement and Patient Consent Form

FAX: (800) 748-0116 **Fax or Mail to** **P.O. Box 3210**

Phone: (800) 748-0130 **Kepro** **Auburn, AL 36831-3210**

Patient Name_____ Patient Medicaid #_____

Patient DOB_____ Patient phone # with area code_____

This document is to help you understand the OPIOID DEPENDENCE drugs you will be taking and to make sure that you and your doctor/health care provider follow all state and federal regulations concerning the prescribing of controlled substances. For you to be treated with these drugs you need to understand and agree to the following:

- I understand that these drugs are controlled substances. They are highly monitored by local, state, and federal laws.
  - I understand that it is a felony to use these drugs without a prescription. I cannot give or sell them to anyone else.
- I will not request other controlled drugs from any other doctor. Taking other controlled drugs can be dangerous and may result in my treatment being stopped.
  - I will inform my doctor of all drugs I am taking.
    - This includes anxiety drugs, pain drugs, cough syrups, and alcohol. Drugs like these can interact with this drug and are not allowed during treatment.
  - I understand that mixing this drug with other drugs can be dangerous. It is especially dangerous to mix this drug with benzodiazepines like Ativan® (lorazepam), Klonopin® (clonazepam), Valium® (diazepam), or Xanax® (alprazolam). I also know that several deaths have happened when people mixed buprenorphine (for example Suboxone®, Zubsolv®, or Bunavail®) and benzodiazepines.
- While taking this drug I will not use any illegal drugs, such as cocaine, heroin, marijuana, etc., or drugs that are not prescribed to me. Using illegal drugs or drugs not prescribed to me may cause a change to my treatment plan, including stopping my treatment.
- I agree to take the drug only as prescribed.
  - I will not change the dose on my own. I understand the goal is to slowly decrease the total daily dose according to my doctor's instructions.
  - I understand that increasing my dose or taking more than prescribed could cause an overdose. I understand that taking more than prescribed is a misuse of the drug.
- I agree that the drug I receive is my responsibility. I will keep it in a safe and secure place. I understand that lost drugs will not be replaced no matter what the reason for the loss.
- I agree to be compliant with all my required drug screenings.
- I will follow all instructions my doctor gives me to make sure I am taking my medicine correctly, such as drug counts.
- I authorize the doctor to provide a copy of this agreement and information about these drugs to the Alabama Medicaid Agency for purposes of treating me and monitoring my use of this drug. I understand that I can end this authorization at any time, except if someone who can legally hold and use this information has already acted on it. If I have not ended this authorization, it will end when my doctor no longer prescribes this drug for me.
- I am aware of the side effects of taking this drug. This drug can cause side effects including headaches, trouble sleeping, digestive issues, sweating, or weakness. Many of the drugs used in opioid dependence treatment cause signs and symptoms of dependence. This includes withdrawal signs and symptoms when the drugs are being decreased, or when they are stopped.
- These instructions have been fully explained to me. I agree to follow all of these instructions. All of my questions and concerns about this treatment have been answered. A copy of this agreement has been given to me.
- I understand that my treatment may be stopped if I break any of this agreement.

By signing this agreement, I acknowledge that I have read the above information. I will abide by all parts of it. I understand if I do not abide by all parts of this agreement the drug may be stopped.

Patient Printed Name Patient Signature Date

Prescriber Printed Name/NPI Prescriber Signature Date

Prescriber Attestation: As the Prescriber of Opioid Dependence Treatment drugs, by my signature above, I attest that either I or my representative have explained the contents of this form to the Patient identified above. I further attest that I have reviewed the patient's medical records in the state's Prescription Drug Monitoring Program (PDMP), and to the best of my knowledge, the patient is not diverting or otherwise misusing the requested medication.