*This sample Medication Management Agreement contains elements that promote patients’ understanding of their role and responsibility in their pain management treatment process. This sample agreement should be adapted to reflect the policies and procedures of individual medical practices. Some items appear in bold-faced type for emphasis. Items in bold and italic type may be formatted according to physicians’ preferences.*

**Medication Management Agreement**

The decision to use opioid (narcotic) medications was made because of my specific condition or because other treatments have not helped my pain. Because Dr. ***(your name)*** is prescribing such medication for me to help manage my pain, when I sign this form I acknowledge that I understand and agree to the following conditions to make my treatment as safe and successful as possible (please initial each numbered item):

1. I am aware that the use of such medicine has certain risks associated with it, including but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia (pain reduction), addiction, and the possibility that the medicines will not provide complete pain relief.
2. I understand that the main treatment goal is to improve my ability to function by reducing pain. In consideration of that goal and the fact that I am being given potent medication to help me reach that goal, I agree to help myself by following better health habits: exercising, controlling my weight, and avoiding the use of alcohol and tobacco. I understand that only by following a healthier lifestyle can I hope to have the most successful outcome to my pain management treatment.
3. I understand that the long-term advantages and disadvantages of chronic opioid use have yet to be fully determined and that treatment may change while I am under Dr. (***your name***)’s care. I understand, accept, and agree that unknown risks may be associated with the long-term use of controlled substances and that my physician will advise me as knowledge and training advances are made, and will make appropriate treatment changes. I also know there may be other non-opioid options for my pain control.
4. I agree to tell my doctor about all other medicines and treatments that I am receiving. **I will not request or accept controlled substances/medications from any other physician or individual** while I am receiving such medications from Dr. (***your name***). To do so may endanger my health and/or our physician/patient relationship. The only exception is medication prescribed while I am admitted to a hospital.
5. I understand the following refill policy:

***(for example)***

* 1. ***The daily dose may not vary. The weekly/monthly dose must remain constant.***
  2. ***Medications will not be refilled early, even if they have been lost.***
  3. ***Medications will not be refilled on Fridays, weekends, or holidays.***
  4. ***Medications will not be refilled by other physicians.***

1. I agree to use (***name of pharmacy***) pharmacy, located at (***address and telephone number of pharmacy***) for all my pain medications. If I change pharmacies for any reason, I agree to notify the doctor at the time I receive a prescription and advise my new pharmacy of my prior pharmacy’s address and telephone number.
2. I agree to **keep all scheduled appointments**.
3. At each visit, Dr. (***your name***) will evaluate me for pain relief, side effects, function, and abnormal behavior (anything indicating addiction). I understand that evaluation may also include recommended lab work to monitor my medication’s efficacy. I must keep Dr. (***your name***) fully informed of any changes, Emergency Room visits, lost or stolen medications or any other circumstances affecting my health and well-being.
4. Dr. (***your name***) may refer me to another physician for a second opinion while I am receiving controlled substances. I understand that if I do not obtain this second opinion, Dr. (***your name***) may discontinue my medications or refill them with a tapering dose to therapeutically and safely discontinue my use of them.
5. You have my permission to discuss my ***(medical condition/medication management)*** with my spouse or significant other. (***Optional: include space to write in name of spouse or significant other.***)
6. I understand that driving a motor vehicle may be hazardous while taking controlled substances and that it is my responsibility to comply with the laws of this state and conduct myself safely while taking the medication prescribed.
7. I will not be involved in activities that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include but are not limited to: using heavy equipment or operating a motor vehicle, working at unprotected heights, or being responsible for another individual who is unable to care for himself or herself.
8. I have been fully **informed** by Dr. (***your name***) regarding the potential psychological **dependence** on a controlled substance. I know that some persons may develop a tolerance, which is the need to increase the dose of the medication to achieve the desired effect. I know that I may become physically dependent on the medication. This will occur if I am on the medication for several weeks; when I stop the medication, I must do so slowly and under medical supervision or I may have withdrawal symptoms.
9. **I understand that if I fail to comply** with the guidelines in this agreement and on my prescription labels; if I obtain narcotics elsewhere (even from a physician); if I use illicit drugs; if I share narcotics with others; or if I alter a prescription, our doctor-patient relationship will be terminated.

**I have read this agreement. I fully understand the consequences of violating this agreement. Dr. (*your name*) has answered my questions and I agree to the terms of the agreement.**

Patient name:

Patient signature and date:

Witness signature and date:

□ Copy given to patient

**Some physicians may wish to include additional statements in their medication management agreements, such as:**

* I will take my personal medications as directed, no more and no less. I will not tamper with prescribed medications by cutting, crushing or by any other means altering the intended dose of medication. I will not take the medications by any other than the directed route of administration (oral, trans-dermal, or rectal).
* I will not adjust the medications by myself. I will discuss with Dr. (***your name***) any change in dosage I feel I need. Some patients may develop tolerance, which is the need to increase the dose of the medication to achieve the same effect in terms of pain relief. As a result of other treatment modalities or the natural course of my disease process, my pain may decrease. My medication doses will have to be adjusted by Dr. (***your name***).
* I will not hoard my medications. If I am able to control my pain with fewer narcotics, I will inform Dr. (***your name***).
* I am responsible for keeping track of the amount of medications left on my prescription and will plan ahead for arrangements to refill my prescriptions in a timely manner so I will not run out of medications.
* I understand that I must make necessary arrangements to alert Dr. (***your name***) of my need for a refill ***five (5)*** working days before they run out.