Potentially Addicting Medications (PAM)

Medication Class: Opiates, opioids

Examples: morphine, oxycodone, hydrocodone, fentanyl, methadone

The class of medications known as opiates or opioids (sometimes referred to as narcotics) may be a helpful part of chronic pain treatment for some people. However, misuse of these medications may result in serious harm to a patient and, if taken by someone other than those it is intended for (diversion), others are at risk as well. As use of these medicines for pain management has increased in the past 10 years, so too have injuries, addiction and death due to their misuse. Most of these outcomes are unintended and considered accidental. One of the goals of this agreement is to avoid such outcomes.

Risks of Medication and Potential Side Effects

Physical Side Effects: May include mood changes, drowsiness, nausea, constipation, difficulty urinating, depressed breathing, apnea (stopping breathing), itching. Bone thinning and sexual side effects (lowering of male hormones in men and change in periods in women).

Physical Dependence: Sudden stopping of an opioid may lead to withdrawal symptoms including abdominal cramping, pain, diarrhea, sweating, anxiety, irritability and aching.

Tolerance: A dose of an opioid may become less effective over time even though there is no change in your physical condition. If this happens repeatedly, your medication may need to be changed or discontinued.

Addiction: Can occur in anyone. More common in those with a personal or family history of addiction. Can be seen as drug craving, loss of control and poor outcomes of use.

Hyperalgesia: Increased sensitivity to and increasing experience of pain caused by the use of opioids. May require change or discontinuation of medication.

Overdose and Death: Taking more than the prescribed amount of medication or using with alcohol or other drugs (including some prescription medications) can cause you to stop breathing resulting in coma, brain damage or even death.

Sleep apnea (periods of not breathing while asleep): may be caused or worsened by opioids.

Risk to unborn child: Risks to unborn children may include: physical dependence at birth, possible alteration in pain perception, possible increase risk for development of addiction, among other. Tell your provider if you are or intend to become pregnant.

Victimization: There is a risk that you or your household may be the subject of theft, deceit, assault or abuse by persons seeking to obtain your medications for purposes of misuse. These drugs have a "street value" and these drugs increase the chance that you may be a victim of crime.

Life threatening irregular heartbeat: can occur with methadone, Electrocardiogram (EKG) may be needed.

Driving Impairment: You should not drive while taking this medication as it can impair judgement. Being impaired by any medication or substance while driving is against the law in the state of New Hampshire.

Patient Name:

Patient DOB:

Informed Consent and Prescribing Agreement

CHRONIC Controlled Substances (2017 Version)

I understand I am being prescribed a controlled substance and have reviewed the risks and benefits of this medication. Both patients and healthcare providers have responsibility for the appropriate and safe use of controlled substances.

Risks of the particular medication are listed on a **Potentially Addictive Medications ("PAM")** form which is particular to the type of medicine I am on. I have reviewed this PAM and questions have been answered to my satisfaction.

Goals of Treatment

The primary goal of utilizing this medication is to improve my ability to engage in work, home, social and physical activities and ultimately improve my quality of life. This agreement serves as a plan of care to achieve these goals safely and effectively. If these goals are not achieved alternative plans will need to be discussed with my provider. It is not expected that 100% of my symptoms will be relieved with medication.

I understand that my provider is under no obligation to prescribe these medications to me, and that my provider reserves the right to discontinue these medications at any time. If it appears to my provider that there are no clear benefits to my daily function or quality of life from the narcotic medication, or if I develop rapid tolerance or loss of effect from this treatment, I will be gradually tapered off the medication as directed by my provider.

Prescription Management

I will take my medicine as prescribed.

My provider and I agree to meet on a regular basis (at least every six months, but more frequently at the discretion of the provider) to evaluate my progress and functional status. I agree to keep all appointments scheduled for my care.

I understand that using alcohol or illicit drugs with prescription medication is dangerous. I will avoid legal drugs including alcohol, I will not use any illegal drugs including marijuana, cocaine, methamphetamine, LSD, ecstasy, PCP, etc.

I will receive opiate prescriptions from my **primary prescribing providers** (Hereinafter "provider") (or if he/she is not available, a covering provider)

I will not take controlled substance prescriptions from other providers unless discussed with my provider or unless it is an emergency circumstance. I agree to notify other treating providers of my controlled substance agreement. This will include emergency room (ER) providers and surgical specialists among others. ER visits must be relayed to my doctor within 24 hours of discharge. If I have any concerns about medications from other providers, I agree to call my provider.

Prescription refill requests require special review and signatures. Therefore I will call 72 hours (3 business days) in advance. The last daily time for prescription pick-ups will be determined by your provider's office. No refills will be provided by providers on call (either after hours, holidays or weekends). **Early refill requests WILL NOT BE ACCOMODATED.**

I will designate a primary pharmacy which will dispense all of my opiate medications. If this pharmacy cannot dispense the prescription medication or there is another issue with this pharmacy, then I will notify my provider within 24 hours to designate an alternative pharmacy. Failure to notify my provider of an alternative pharmacy will be considered a violation of this contract.

Primary Pharmacy Name and Address:____

I will supply proper identification for my prescription upon receiving it. If my provider and I agree on an alternative person to pick up my prescription, that person must be 18 years or older and they need to provide proof of identification upon pick-up. This person must be a designated individual and I may be asked to sign a Patient Authorization Liaison Form (PALS) form. The provider may at any time refuse to allow an alternative person to pick up the prescription even if designated.

A urine screen for the prescribed medicine and other prescriptions and illicit drugs can be requested at the time I arrive to pick up my prescription or I may be asked during any visit to provide one. **I will be financially responsible for any portion of this test that my insurance does not cover.**

I am responsible for my medications and written prescriptions. I will not share, sell or trade medications. Lost, misplaced, stolen, or accidentally destroyed prescriptions (i.e. printed paper prescriptions) or actual medications **will not be replaced, even if a police report is provided.**

I will safely store medications. Opioids should be stored in a safe and secure place, such as a locked cabinet or safe. **I will not destroy or dispose of medications without specific instructions from my provider.** My provider may instruct me to bring in medications for disposal or use another appropriate method of disposal: medications may be returned to a take-back location or mixed with a small amount of water and an undesirable waste substance such as coffee ground or cat litter. For additional information and resources on safely disposing of medications, go to the website: www.nh.gov/medsafety.

I agree to bring in all of my pill bottles and remaining pills if requested by my provider. I may be asked to come into the office the same day as the notification. I will follow this request to the best of my ability. Failure to comply with this request is considered a violation of this agreement.

I understand that a copy of this agreement may be provided to the ER, pharmacy or other providers involved with my care.

SHOULD I CHOOSE TO USE THIS MEDICATION IN ANY WAY OTHER THAN THAT PRESCRIBED, I AGREE THAT MY PROVIDER WILL NOT BE RESPONSIBLE FOR ANY DAMAGE TO MY HEALTH, OTHER PERSONS, OR PROPERTY.

I UNDERSTAND THAT ANY VIOLATION OF THIS AGREEMENT MAY RESULT IN THE IMMEDIATE TERMINATION OF MEDICATIONS PRESCRIPTIONS, AND POSSIBILY TERMINATION OF ALL SERVICES FROM MY PAIN MANAGEMENT PROVIDER. IF THE VIOLATION INVOLVES SUSPECTED ILLEGAL ACTIVITY, I UNDERSTAND THAT THE INCIDENT MAY ALSO BE REPORTED TO OTHER HEALTHCARE PROVIDERS, PHARMACIES, AND OTHER LEGAL AUTHORITIES, AS REQUIRED BY LAW.

Informed consent: This document has been reviewed with me and my questions have been answered. My signature below verifies I understand the information.

____ ____________________

Patient Signature Date

____ ____________________

Provider Signature Date