R.O.A.D. To A Better Life

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Informed Consent and Treatment Agreement for Subutex®/Suboxone® (Buprenorphine)

Name of Patient _____ Date of Birth:_____

Please initial all items

☐ 1. I understand the frequency of visits will be weekly at first and then biweekly. As my recovery progresses, with the completion of group therapy and maintenance of personal psychotherapy, my visits may extend out to 4 weeks. I understand that if I relapse or miss appointments then I will return to weekly visits until assurance in my recovery is reestablished. I must call 24 hours prior to canceling an appointment. If I miss an appointment without contacting my provider: I may be asked to return to more frequent visits, I may not have my medication refilled until I am seen again, and I may be discharged.

☐ 2. I understand that if I am not seen in the office as prescribed by my provider, I will be unable to obtain my prescriptions and I will be discharged from the ROAD program.

☐ 3. I agree to take Buprenorphine as prescribed/directed at the dosage determined by my providers; and not to allow anyone else to take medications prescribed for me.

☐ 4. I **am required** to participate in therapy in a group and/or individual setting. When therapy is offered at the location of my ROAD provider, I **am required** to attend group/individual therapy at that location. I also understand that **I am required** to attend AA/NA meetings. (Verification of attendance required for AA/NA and for therapy conducted at 'non-ROAD' locations.)

☐ 5. I agree not to take any other medications with Buprenorphine without prior permission from my provider. I understand that overdose deaths have occurred when patients have taken other medications (particularly medications like **Librium®, Valium®, Xanax®, Klonopin®** or other benzodiazepines) with Buprenorphine.

☐ 6. I understand that combining illegal substances with prescribed medication increases my risk of breathing difficulties, heart disorders, and sudden death. If I do so, I may be discharged from the practice.

☐ 7. I understand that the Buprenorphine providers **will not be available** to prescribe medication during evenings, weekends, or after 12 noon on Fridays**.** It is my responsibility to **call my provider at least 2(two) *business* days in advance** of running out of medications.

☐ 8. It has been explained to me and I understand that Buprenorphine itself is an opiate drug, although a partial agonist, it can still produce physical dependency in non-opiate dependent patients.

☐ 9. The goal of treatment of opiate dependency is to learn to live without abusing drugs. Buprenorphine treatment should continue as long as necessary to prevent relapse to opiate abuse/dependence and then be weaned off.

☐ 10. If I have been on Methadone maintenance, I agree that my provider can coordinate my medication switch with the provider of Methadone. This may involve exchange of medical records and discussions with the Methadone clinic, physician or staff. **After switching to Buprenorphine, I will not take Methadone.**

☐ 11. I will submit my own urine specimen for drug screen (narcotic, pot, cocaine, amphetamine, PCP, alcohol, benzodiazepine, and others) upon my provider's request as often as directed. My Buprenorphine provider may ask that a clinical staff member observe me providing the appropriate specimen. If my drug screen indicates the presence of illegal/inappropriate substances, or has no buprenorphine or buprenorphine metabolites, I will be discharged.

☐ 12. I understand that I will be required at any time with short notice to bring in my medication for inspection and counting. If I do not show or have the appropriate amount of medication, I may be discharged. I may never dispose of medication myself without a staff member as a witness.

☐ 13. I understand that I must call **at least 24 hours** prior to any appointment if I need to cancel. If I do not come for my appointment or I fail to provide sufficient notice, I am subject to a 'no show' cash fee.

☐ 14. I allow my provider to communicate with other providers regarding my medical care, consistent with HIPAA guidelines. Treatment disclosure may include, but is not limited to, discussing my medications with the pharmacist. I understand that records released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may contain confidential information about communicable diseases including HIV (AIDS) or related illnesses.

☐ 15. I will not sell, share, or trade my medication with anyone. It is understood that if caught doing so, I will be discharged without the chance to be readmitted.

☐ 16. **I will safeguard my written prescription** and medication from loss**,** damage or theft. We recommend a lock box especially for those with children. Lost, stolen or damaged prescriptions/medications may be replaced at the provider's discretion. If replaced, no prior authorization will be completed and you will be responsible for any prescription costs in such cases.

☐ 17. I will never alter a prescription in ANY way. I understand this is a felony, punishable by incarceration.

☐ 18. I authorize the Buprenorphine provider and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including New Hampshire's Board of Pharmacy and the DEA, in the investigation of any possible misuse, prescription forgery, sale or any other diversion of my medication.

☐ 19. I allow my Buprenorphine provider to receive information from any pharmacy I have used.

☐ 20. I will have all my medications filled only at the pharmacy I have listed below. I will inform my Buprenorphine provider of any pharmacy changes

☐ 21. I understand that rude or disrespectful treatment of staff is not tolerated and may result in my discharge. (Ex: using profanity, raising my voice, making vulgar or inappropriate comments)

☐ 22. [For women of childbearing potential] I agree to tell my physician if I become pregnant or even think I may be pregnant.

☐ 23. I understand that I must provide a viable contact number at all times (and will update the office of any changes) or my provider may not prescribe medications.

☐ 24. I understand the commitment to the program and the many appointments, therefore transportation cannot be an issue or a reason for short notice cancelations or no show appointments.

☐ 25. I understand that my prescription will need to be filled immediately following my appointment while our staff is still available to take care of any questions or issues at the pharmacy.

I have read and understand the above details about buprenorphine treatment and I wish to be treated with buprenorphine.
I have been given the opportunity to have any questions addressed regarding the above.

Name _____

Pharmacy _____ Town _____ Phone _____

Primary Care Provider _____ Town _____ Phone _____

Signature _____ Date _____

☐ **2 copies given to patient**
Two copies of this form are to be given to the patient after they sign; one for their records and one for the Pharmacy's records.