

MEDICATION AGREEMENT

The following agreement relates to my use of medications prescribed for pain control by my treating physician and any other physician or health care provider treating me on his behalf or under his supervision. "Medications" are defined as controlled substances (for example narcotics) and all other medications (for example, all opiates and/or benzodiazepines) prescribed for pain control.

I acknowledge that taking medications in excess of or in addition to these prescribed may create a risk of harm to me, including but not limited to physical injury, addictive behavior, and a lessened effectiveness of the prescribed medication. I acknowledge that the rules stated below are for my benefit.

I recognize there are federal, state, and individual physician and/or institutional policies regarding the use of controlled substances or addictive medications. The Texas Intractable Pain Treatment Act, the Texas State Board of Medical Examiners, and the Texas State Board of Pharmacy all have specific requirements for the use of controlled substances and addictive medications for the treatment of chronic intractable pain. I understand the physician identified above is under no obligation to provide me with these classes of medications. I further understand that I will be provided with controlled substances and addictive medications while participating in this program only if I adhere to the following requirements:

1. I will use the substances only in the amount and as prescribed and as directed by my CareFirst Prescribing Physician.
2. I will not purchase, accept, ingest, or otherwise consume any controlled substances, prescription medications, or addictive medications under any circumstances without obtaining the express permission of my CareFirst Prescribing Physician. Information that I have been receiving these substances from any other source may lead to a discontinuation of medications and treatment.
3. I agree to submit to urine and blood screens to detect the use of substances not prescribed by my CareFirst Prescribing Physician at his request.
4. I recognize that my chronic pain represents a complex problem, which may benefit from physical therapy, psychotherapy, and behavioral medicine strategies. I also recognize that my active participation in the management of my pain is extremely important. I agree to actively participate in all aspects of the pain management program as directed by my CareFirst Prescribing Physician to secure increased functioning and improved coping with my condition.
5. I will use only one pharmacy, the identity of which I will provide to my CareFirst Prescribing Physician. I authorize my CareFirst Prescribing Physician to provide my pharmacist with a copy of this agreement.
6. I agree to notify my CareFirst Prescribing Physician promptly of any other physician or health care provider that provides me with treatment outside the scope of this program.
7. I am not currently engaged in the illegal use, sale, or possession of any controlled substances, nor do I consume excessive amounts of alcohol. I am not currently under treatment for use of controlled substances or alcohol.
8. I certify that I am not pregnant, and that I will inform my CareFirst Prescribing Physician immediately should I become pregnant.

In order to ensure compliance with the above-listed requirements, it is recommended you utilize a single pharmacy. Please list your pharmacy of choice in the space that follows. If you are unaware of a particular pharmacy in your area, a list of area pharmacies will be provided to you upon request. If, during the course of your treatment you wish to change pharmacies, please notify either the doctor or his assistant.

Pharmacy	Location	Phone Number
<p>I UNDERSTAND THAT FAILURE TO ADHERE TO THE ABOVE REQUIREMENTS MAY RESULT IN A DISCONTINUATION OF MEDICATIONS AND TREATMENT.</p>		

I further understand that I will not receive replacement medications for "lost" or "stolen" medications (unless I file a report with my insurance company and police department). I will not expect to receive additional medication prior to the time of my next scheduled refill, even if my prescription runs out, unless I have made prior arrangements with my CareFirst Prescribing Physician.

I further understand that my CareFirst Prescribing Physician is not responsible for medicines or treatments prescribed by any other health care providers. I understand that if it appears to my CareFirst Prescribing Physician that there is substantially little demonstrable benefit to my daily function or quality of life from the medication, I may be required to gradually taper my medication as prescribed and directed by my CareFirst Prescribing Physician. I will not hold my CareFirst Prescribing Physician, CareFirst Medical Associates, or any of its employees and/or agents liable for problems caused by discontinuation of my medications.

Patient's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____