

## Buprenorphine Treatment Agreement

1. I understand that buprenorphine is a narcotic drug that can produce a 'high'. I know that taking buprenorphine regularly can lead to physical dependence and that if I abruptly stop taking it, I could experience symptoms of opioid withdrawal.
2. I understand that Suboxone also contains naloxone. Naloxone will counter act any opioid I'm taking causing precipitated withdrawal. I understand I must take Suboxone as ordered and follow instructions outlined.
3. My attending physician has discussed with me various options for treatment of my addiction, including non-pharmacological options. He or she has explained, and I understand, the risks and benefits of Suboxone, including potential side effects. I understand that in order to be a satisfactory candidate for Suboxone I must follow certain safety precautions for the treatment and comply with the treatment the schedule prepared for me by my attending physician and/or my substance abuse counselor. Additionally, my attending physician has discussed this agreement with me and explained what is expected of me in the program. I understand the treatment program and have been given information about the program and adequate time to have my questions answered. As a result, I voluntarily consent to the program.
4. I will take Suboxone by placing it under my tongue to dissolve and be absorbed. I will never inject Suboxone or take it intravenously (IV), because IV use could lead to sudden and severe opiate withdrawal.
5. I will not drive a motor vehicle or use power tools or other dangerous machinery while taking Suboxone until my doctor has cleared me to do so.
6. I will inform my MAT provider of all my other doctor and dentist appointments, and any medications (prescription or non-prescription) that I am taking. I will also report any change in my medical history.
7. I understand that it can be dangerous to mix Suboxone with alcohol or other sedatives (such as Valium, Ativan, Xanax, Klonopin, Librium), benzodiazepines – so dangerous that it could result in accidental overdose, over-sedation, organ failure, coma, or death. I agree to abstain from **ALCOHOL** and **SEDATIVES** while I am being treated with Suboxone. I understand this is important for my safety and to assure that another medication is not prescribed which may lead to harmful side effects.
8. I agree to abstain from all drugs, including alcohol, marijuana, and other street drugs. I understand that continued use of drugs can interfere with my attempts at recovering from opioid dependence. I also understand that buprenorphine (as found in Suboxone) is designed to treat opioid dependence, not addiction to other classes of drugs. Therefore, I will work with the MAT provider to design an individualized treatment program to assist me in discontinuing the use of other drugs.
9. My medication must be protected from theft or unauthorized use. I understand that Suboxone must be stored safely, and securely where it cannot be taken accidentally by children, pets, or be stolen. If my medications are stolen, I will file a report with the police and bring a copy to my next visit. If another person ingests my Suboxone, I will immediately call 911 or Poison Control at 1-800-222-1222. I agree to take full responsibility for the safekeeping of my buprenorphine. Lost or stolen buprenorphine will not be refilled before the date it was due to be renewed unless I can give the clinic a copy of the police report of the loss. I understand my physician reserves the right to refuse refills.

10. I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without recourse for appeal.
11. If I alter or forge a prescription I understand that my MAT provider will terminate my care immediately and will inform the pharmacy and legal authorities of this felony act.
12. I agree to participate in a regular program of professional counseling as recommended by the practice staff, while being treated with buprenorphine. If my substance abuse counselor is located outside of the clinic, I will provide proof of regular substance abuse therapy attendance (which may be in the form of a note from my substance abuse counselor) at each visit to my attending physician.
13. I agree to receive support from peers as recommended by the MAT clinic staff, and agree to invite significant persons in my life to participate in my treatment.
14. I agree that a network of support is an important part of my recovery, and honest communication among people within the network is important for my treatment. I will provide authorization to allow telephone, email, or face-to-face contact, between the MAT clinic staff and physicians, therapists, probation or parole officers, the Department of Social Services, and parents to discuss my treatment and progress. I consent to allow the staff of the MAT clinic to provide others with information regarding my medication usage as needed for my treatment or as otherwise permitted or required by law.
15. I understand that buprenorphine can only be prescribed by a specially licensed physician (buprenorphine provider). I can only get buprenorphine refills during scheduled office visits with my buprenorphine provider and I will not be able to obtain buprenorphine refills during walk-in visits, after regular clinic hours or on weekends.
16. I must take my medications as instructed by my buprenorphine provider. I cannot change the way I take my medications or adjust the dose until approved by my buprenorphine provider.
17. I agree to see my buprenorphine provider on a regular basis. The frequency of visits will be up to my buprenorphine provider and will be explained to me.
18. If I miss an appointment or if I need to reschedule an appointment for a later date, I understand that my medications will not be refilled until the time of my next scheduled appointment with a buprenorphine provider. I understand that if I miss, or am late to, three appointments and did not call the clinic in advance, and provide at least 24hr notice, I will be dismissed from the buprenorphine maintenance clinic and I will not be given any refills for my medication. I may also be given a lower dose, enough to sustain and avoid withdrawal.
19. I understand my buprenorphine provider or designee will monitor my compliance by counting my buprenorphine tablets. I agree to bring my buprenorphine medication to each buprenorphine clinic visit.
20. I understand that I may be asked to bring in my Suboxone medication to be counted at any time and will come into the office within 24 hours of receiving such a request.
21. I understand that my buprenorphine provider will monitor my medication compliance by doing urine or blood drug screens at each visit at my cost. I consent to testing for this purpose and I understand that it is a requirement of my participation in the buprenorphine clinic. Drug screens will be "supervised", and that a staff person will be required to be present in the restroom with me in order to ensure that the test specimen is coming from my body.

22. I agree to notify the clinic immediately in case of relapse to drug abuse. Relapse to opiate drug abuse can be life threatening, and an appropriate treatment plan must be developed as soon as possible. I understand the physician should be informed about a relapse before any urine test shows it.
23. My provider has recommended that I obtain my buprenorphine from a single pharmacy. The pharmacy I would like to designate is:
- Pharmacy Name/location: \_\_\_\_\_
- Pharmacy Phone: \_\_\_\_\_
24. I agree to conduct myself in a courteous manner in the physician's or clinic's offices.
25. I agree to pay all office fees for this treatment at the time of my visits. Failure to do so is cause for immediate termination of services.
26. I understand that if I do not uphold this agreement, I will be dismissed from the program.



**This agreement is entered into on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ .**

**Patient's name** \_\_\_\_\_ **Date of birth** \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
(Print)

**Patient's signature** \_\_\_\_\_

**Provider's name** \_\_\_\_\_  
(Print)

**Provider's signature** \_\_\_\_\_