St. Clair County Community Mental Health Authority

Buprenorphine Requirement Agreement

Individual Name: _____ Case #: _____ Date: _____

As a participant in Buprenorphine treatment for opioid dependence, I freely and voluntarily agree to accept this agreement as follows:

1. _____I agree to behave respectfully, as well as keep and be on time to all of my scheduled appointments.

2. _____I agree that my Buprenorphine prescription will be written at my scheduled appointments with my prescriber. Missing appointments can subject me to drug withdrawal reaction.

3. _____I am aware that Buprenorphine is not prescribed at CMH for the purpose of pain management. I have been informed that if I am seeking Buprenorphine for pain management, I should look for another Buprenorphine prescriber in the community.

4. _____I agree to obtain a primary care physician. Proof of upcoming appointment may be requested. I agree to sign a consent for CMH and primary care physician and any other treating physicians for coordination of care.

5. _____I agree to have all psychotropic medications prescribed by CMH prescriber.

6. _____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 will result in my prescription being terminated.

7. _____I am aware that I will at random be required to submit to urine drug screens, breathalyzer testing, and pill/film counts. If I request to have an earlier session for Buprenorphine provision, I understand I will be required to bring all remaining Buprenorphine as early release will not be granted for replacement of missing supply.

8. _____I agree that the medication I receive is my responsibility. I agree that lost medication will not be replaced regardless of why it was lost. I will not leave my mediation in a public part of my home, leave the labeled bottle/bag/box open, or store the bottle/bag/box near water and I will store it out of the reach of children. Medication must be accounted for at all times.

9. _____In the instance of a planned medical or dental procedure requiring administration of controlled substances/medications, I agree to independently obtain office documentation identifying medications to be administered during procedure. This documentation must be submitted to Suboxone RN. I understand that failure to provide this documentation prior to planned procedure may result in immediate discontinuation of my Buprenorphine prescription.

10. _____I agree not to obtain controlled medications from any doctors, pharmacies or other sources without first requesting approval from the prescriber prescribing Buprenorphine.

11. _____I agree to carry my medication in its prescription bottle or carry a copy of the prescription label.

12. _____I understand that mixing Buprenorphine with alcohol or other drugs especially benzodiazepines *(Valium, Ativan, Klonopin, Xanax, etc.)* can be dangerous and is not allowed under the terms of this agreement. I have been informed that several death have occurred among persons mixing Buprenorphine and benzodiazepines.

13. _____I will avoid the use of benzodiazepines, alcohol, kratom, opioids, cocaine, methamphetamine, barbiturates *(e.g., Fioricet, Fiorinal, etc.),* Tramadol, stimulants and all other addicting substances.

14. _____I will avoid consumption of all poppy seed products *(e.g., muffins, everything bagels, salad dressings, etc.).*

15. _____I understand that a positive urine drug screen for anything other than Buprenorphine or positive breathalyzer in the CMH office will result in the immediate discontinuation of Buprenorphine.

16. _____I agree to take my medication as the prescriber has instructed and not to alter the way I take my medication without first consulting my prescriber.

17. _____I understand that medication alone is not sufficient treatment for my condition and I agree to participate in counseling *(individual, group and 12 step program)* as discussed and agreed upon with my prescriber and specified in my Treatment Plan. I understand failure to do so may result in immediate discontinuation of my Buprenorphine prescription.

18. _____If leaving town or will be otherwise unavailable, I will contact nurse/prescriber to inform them of my plans. I agree to make sure that my most current contact number is always on file with CMH.

19. _____I understand that I must obtain a Narcan/Naloxone kit within four (4) weeks of being accepted into the program.

20. _____I have been provided the opportunity to discuss this agreement with the nurse/prescriber and agree that violation of any part of this agreement may be grounds of termination of the Buprenorphine prescription.

21. _____I have received a copy of this agreement.

_____ _____
Individual Signature Date

_____ _____
RN Signature Date

_____ _____
Prescriber Signature Date