St. Clair County Community Mental Health

Buprenorphine Requirement Agreement

Individual: _____ 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 reactions.

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

4. _____ I agree to obtain a primary care physician. Proof of upcoming appointments may be requested. I agree to sign a consent for SCCCMH, my primary care physician, and any other treating physicians for coordination of care.

5. _____ I agree to have all psychotropic medications, including tranquilizers and medications for sleep, prescribed by my SCCCMH 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 Buprenorphine 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. I understand that if I miss a random urine drug screen, breathalyzer testing, or pill/film count with the Suboxone RN that my Buprenorphine dose will be decreased by one half film.

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. I agree to store my medication away from water and out of the reach of children. I understand that early prescriptions will not be granted for replacement of missing supply. 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 *(e.g., Valium, Ativan, Klonopin, Xanax, etc.)* can be dangerous and is not allowed under the terms of this agreement. I have been informed that several deaths 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 alcohol, kratom, opioids, cocaine, methamphetamine, barbiturates, Tramadol, or stimulants will result in my Suboxone dose being decreased by one half film per occurrence, with the exception of Xylazine, Fentanyl, or Benzodiazepines which will result in the immediate termination of my Buprenorphine prescription due to increased risk of death.

16. _____ I agree to take my medication as the prescriber has instructed and to not alter the way I take my medication without first consulting my prescriber. I understand that if I overtake my medication, I will not be provided additional medication until the next scheduled dosing appointment with the Suboxone RN.

17. _____ I understand that monthly Buprenorphine dosing appointments will be considered after 1 year of consistent urine drug screens. I understand that a positive urine drug screen after this time will result in being transitioned to increased frequency Buprenorphine dosing appointments.

18. _____ I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in individual counseling as discussed and agreed upon with my prescriber and specified in my treatment plan. I understand that group counseling and a 12-step program may be encouraged by my treatment team. I understand failure to participate in any required counseling may result in immediate discontinuation of my Buprenorphine prescription.

19. _____ If leaving town or will be otherwise unavailable, I will contact the RN/prescriber to inform them of my plans. I agree to make sure that my most current contact number is always on file with SCCCMH.

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

21. _____ I have been provided the opportunity to discuss this agreement with the RN/prescriber and agree that violation of any part of this agreement may be grounds of termination of my Buprenorphine prescription.

22. _____ I have received a copy of this agreement.

_____ _____
Participant Signature Date

_____ _____
RN Signature Date

_____ _____
Prescriber Signature Date