PennState Health

CONTROLLED SUBSTANCE AGREEMENT

Patients Name	
Date of Birth	
Patient MRN	
PSHMG Practice Site	
Treating Provider	

I understand that I have the right to comprehensive pain management. Controlled substances or narcotics are medications that are closely regulated by the Food & Drug Administration ("FDA") and Drug Enforcement Agency ("DEA") and used to treat such conditions as pain, anxiety, and Attention Deficit/Hyperactivity Disorder. Due to the potential dangers of these medications, including addiction, negative drug interactions and the risk of overdose, I agree to enter into this agreement for use of a controlled substance to help prevent inappropriate use of these medications and the potential for addiction. I understand that failure to follow any of the agreed upon statements may result in the discontinuation of these medications and/or referral from Penn State Health and all related providers to an addiction treatment program.

I agree to undergo pain management/controlled substance medication treatment at this ***Penn State Health Medical Group*** Practice Site for my diagnosis of _____. I agree to the following statements to ensure that I am using my medications in a safe and therapeutic manner:

1. I will not accept any controlled substance prescriptions from any other treating provider, unless approved by the treating provider of this agreement.
2. I will not go to emergency rooms, urgent care, walk-in facilities, or specialty provider for pain management of/or medication for my chronic condition for which I am receiving this treatment unless directed to do so by the treating provider. This agreement does not prevent me from going to the emergency room, urgent care, walk-in facilities, or specialty provider for new acute pain of any nature or for any other reason I deem necessary excluding pain management of my chronic condition as previously indicated. I agree to disclose that I have a controlled substance agreement to any new or intervening treating provider so they are aware. I will phone the Practice Site within a week to report any emergency room, urgent care, walk-in facility, or specialty provider visit for which I was treated for acute pain or in which I received a controlled substance.
3. I understand that according to the CDC guidelines, doses higher than 90 morphine equivalent doses (MED) for pain not related to cancer should be avoided. Research indicates that higher doses exponentially increase the risk of serious complications including death. I understand that our goal will be to decrease your daily dose if it is higher than 90 MED.
4. I am aware that my provider is required to query the Pennsylvania Drug Monitoring Program each time he/she is prescribing a controlled substance. Any red flags identified by this query may result in the termination of this Agreement.
5. The goal of treatment with controlled substances is to decrease pain and improve my quality of life. If the prescribing provider feels I am not benefitting from chronic opioid therapy he/she may taper me from these medications or refer me to a medication-assisted treatment program.
6. My physician has discussed the significant risks associated with chronic opioid therapy. These include but are not limited to sedation, constipation, and in some instances death.
7. I am responsible to make sure that I do not run out of my medications on weekends or holidays, because abrupt discontinuation of these medications will cause severe withdrawal symptoms. I must give 72 hours' notice for prescription refills. Requesting early refills will be considered a violation of this Agreement and grounds for discontinuation of the medication and/or referral from the Practice Site to a drug rehabilitation program. No prescriptions will be filled the same day unless I am presenting for a scheduled appointment.
8. I understand that I must keep my medications in a secure place and that the Practice Site will not supply additional refills of any medications that I may lose. Stolen medications will not be replaced.
9. I will not give, sell, or trade my prescriptions to anyone else.
10. I will use only one pharmacy. It is _____ and the phone number is _____
11. I will keep my scheduled appointments with the Practice Site unless I notify the Practice Site at least 24 hours in advance No-shows and/ or cancellations may result in discontinuation of the medication and referral from the Practice Site to a drug rehabilitation program.
12. I agree to refrain from all illicit and/or illegal drugs. I also agree to notify the Practice Site of any mind/mood altering medications such as antihistamines, sedatives, antidepressants and muscle relaxants that are either prescribed by another provider or obtained over the counter.
13. I agree to random urine drug screens and understand that this is a method to detect appropriate and inappropriate use. Depending on my insurance, I acknowledge there may be an additional fee for such tests and I will be responsible for the costs of such testing if not covered by my insurance.

14. I understand that pain medications are only one aspect of my pain treatment plan. I also agree to the following modalities of treatment, if indicated and appropriate, which include but are not limited to, completing requested testing, specialty appointments, and follow up appointments.

    Other medications: _____

    Physical therapy/exercise: _____

    Dietary changes: _____

    Smoking Cessation: _____

    Psychological Counseling:_____

15. My treatment plan may change, including changes in medications and modalities, as deemed appropriate by my treating provider based on the effectiveness of the plan. Failure to follow the treatment recommendations and plan may result in discontinuation of the medication(s) and/or my dismissal from the Practice Site and/or all the practices of Penn State Health with an appropriate referral to a drug rehabilitation program. I will, if requested, provide documentation that I have followed my treatment plan.
16. This Agreement will be in effect until medications are no longer needed, but can be modified at any time should changes in my treatment plan occur. This includes changes in medication and/or dose, transfer of care to another provider or at any time my provider determines it is necessary to update the Agreement.
17. I certify that the information I have provided regarding my pain history is accurate and complete.
18. I understand that a copy of this Agreement will be included in my medical record.

    _____ I have read and understood the above items related to my treatment with controlled substances.

    (Patient Initials) I have had the opportunity to ask questions and all questions have been answered to my satisfaction.

Termination Clauses

A. My treating provider at the Practice Site may terminate this Agreement at any time if he or she has cause to believe that I am not complying with the terms of this Agreement, or that I have made a misrepresentation or false statement concerning my pain or my compliance with the terms of this Agreement.

B. Depending on the violation, I may or may not be provided with additional medication for weaning purposes. The Practice Site will provide information on addiction treatment and detoxification facilities if needed.

C. I understand that I may terminate this Agreement at any time, however my termination of this Agreement may result in the discontinuation of these medications and/or dismissal from the Practice Site and/or all the practices of Penn State Health.

D. I also acknowledge the Practice Site has a legal obligation to report any illegal activity it reasonably suspects to law enforcement agencies and insurance companies.

_____ I have read and understood the above items related to my treatment with controlled substances.

(Patient Initials) I have had the opportunity to ask questions and all questions have been answered to my satisfaction.

If my treating provider terminates this Agreement, I understand that I will no longer be prescribed controlled substances from the Practice Site.

In addition, failure to follow any of the agreed upon statements above may result in dismissal from the Practice Site and/or all the practices of Penn State Health. If I am dismissed, I agree to seek care from another provider, including but not limited to, medication assisted therapy and will strongly consider treatment for addiction.

_____ _____AM/PM

Patient Signature Date/Time

_____ _____AM/PM

Provider Signature Date/Time

_____ _____AM/PM

Witness Date/Time

Initial medication/s and dose:_____

Patient accepted copy of agreement. ☐ YES ☐ NO