

**University Pain Medicine Center**  
**Didier Demesmin, M.D.**

**Agreement for Opioid Maintenance Therapy**

This Agreement between \_\_\_\_\_ (patient) and University Pain Medicine Center is for the purpose of establishing an agreement between doctor (physician) and patient on clear conditions for the prescription and use of pain controlling medications. Doctor and patient agree that this agreement is an essential factor in maintaining the trust and confidence necessary in a doctor/patient relationship.

1. You agree to have UPMC prescribe and monitor all opioid medications and adjunctive analgesics.
2. You agree to use one pharmacy to obtain all opioid prescriptions and adjunctive analgesics prescribed by your physician. If it is necessary to use another pharmacy, you will inform UPMC within three business days.  
Pharmacy: \_\_\_\_\_ Phone Number: \_\_\_\_\_
3. You agree to inform your physician all medications you are taking including herbal remedies and over the counter medications.
4. You will be seen on a regular basis and given prescriptions for enough medication to last from appointment to appointment. You agree to use the medications as prescribed and not more. If you overuse your medications, you may run out and be without medication until your next appointment. Your physician is not obligated to give you additional medication until your next appointment.
5. Appointments are made at regular intervals to insure you have enough medications. It is your responsibility to make an appointment. If you change, cancel or miss your appointment, you may be without medications for a period of time until an appointment can be scheduled. Walk-ins are not allowed.
6. Prescriptions will be given only during office hours. No refills of any medications will be done during off business hours, evenings or on weekend. All refills require 48 hours prior notice.
7. You must bring back all opioid medications in the original bottle at each office visit.
8. You are responsible for keeping your medications in a safe and secure place, such as a locked cabinet or safe. You are expected to protect your medication from loss or theft. Stolen medications should be reported to the police and your physician may choose not to replace the medications or to taper and discontinue the medications.
9. Any evidence of drug hoarding, acquisition of any opioid medication or adjunctive analgesia from other physicians (which includes emergency rooms), uncontrolled dose escalation, loss of prescriptions, or failure to follow the agreement may result in termination of the doctor/patient relationship. If you require emergency treatment, you agree to inform UPMC within three business days.
10. You agree not to use any illicit substances, such as cocaine, marijuana, amphetamines, etc, while taking these medications.
11. You agree not to use alcohol while taking opioid medications.
12. You agree and understand that your physician reserves the right to perform unannounced urine drug testing. If requested to provide a urine sample, you agree to cooperate. If you decide not to provide a urine sample, you understand that your doctor may change your treatment plan, including safe discontinuation of your opioid medications or complete termination of the doctor/patient relationship. You agree to be financially responsible for the urine drug testing if it is not covered by your insurance company.
13. You agree to a psychological evaluation and treatment if your physician feels it is necessary.
14. You agree to allow UPMC to contact any healthcare professional, family member, pharmacy, legal authority or regulatory agency to obtain or provide information about your care or actions if the physician feels it is necessary.
15. You agree to a family conference or a conference with a close friend or significant other, if the physician feels it is necessary.

I have read and understand the above agreement or have had it explained to me and agree to its terms so that Dr. \_\_\_\_\_ and other UPMC providers can provide quality pain management using opioid therapy to decrease my pain and increase my function. I understand that any violations of this agreement may result in my doctor changing or discontinuing my medications, changing my treatment plan, or terminating the doctor/patient relationship.

Patient Name \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Witness: \_\_\_\_\_