Department of Social and Health Services (DSHS) Medicaid

Chronic Pain Agreement

I,_____(*patient receiving chronic pain medications),*agree to correctly use pain medications prescribed for me as part of my treatment for chronic pain. I understand that these medications may not get rid of my pain but may decrease the pain and increase the level of activity that I am able to do each day. I understand that the Pain Management Clinic will deal with my chronic pain and will not deal with any of my other medical conditions.

I understand that _____(name) will be my pain management provider and the only provider who will be ordering medications for my chronic pain.

I understand that I have the following responsibilities (initial each item you agree to):

_____I will only take medications at the amount and frequency prescribed.

_____I will not increase or change how I take my medications without the approval of my pain management provider.

_____I will not ask for refills earlier than agreed. I will arrange for refills **ONLY** during regular office hours. I will make the necessary arrangements before holidays and weekends.

_____I will get all pain medications only at one pharmacy. I will let my pain management provider know if I change pharmacies.

Pharmacy:_____Phone Number:_____

_____I will allow my pain management provider to provide a copy of this agreement to my pharmacy.

_____I will not ask for any pain medications or controlled substances from other providers and will let my pain management provider know of all medications I am taking, including non-legal drugs.

_____I understand that other physicians should not change doses of my pain medications made by another provider.

_____I will notify the Pain Management Clinic of any changes to my pain medications made by another provider.

_____I will let my other health care providers know that I am taking these pain medications and that I have a pain management agreement.

_____In event of an emergency, I will give this same information to emergency department providers.

_____I will allow my pain management provider to discuss all my medical conditions and treatment details with pharmacists, physicians, or other health care providers who provide my health care for purposes of care coordination.

_____I will inform my pain management provider of any new medications or medical conditions.

_____I will protect my prescriptions and medications. I understand that lost or misplaced prescriptions will not be replaced.

_____I will keep medications only for my own use and will not share them with others. I will keep all medications away from children.

_____In addition, I will do the following (initial each box):

_____I must make an appointment with a drug and alcohol counselor and bring proof of following my treatment plan. Contact number is 1-800-562-1240)

_____I must take a drug test this often: _____

_____I agree to pill counts to prove I am using my medications correctly

_____If I fail a drug test, I will take the drug test more often at (frequency of) _____

_____If I fail a drug test, I will be referred to Medicaid's Patient Review and Coordination Program that restricts me to certain providers, such as a primary doctor. (http://maa.dshs.wa.gov/PRR)

_____If I sell my narcotics, my name will be referred to the DSHS fraud unit.

_____If I fail all of the above, I will be discharged from your care with no notice.

Should any of the above not show good faith efforts and my providers feel they can no longer prescribe my pain medications in a safe and effective way, I may be notified and discharged from their care.

I agree to use only the following providers. I will notify my physician of any changes in my health crae and/or changes in my providers.

Provider: _____Clinic:_____Phone:_____

Provider: _____Clinic:_____Phone:_____

Patient Signature: _____

Provider Signature: _____