AGREEMENT FOR TREATMENT WITH SUBUTEX/SUBOXONE

Date:_____ Name of patient: _____

By signing below, I agree to the following:

1. I understand that Buprenorphine treatment for opiate dependence is most effective when combined with drug abuse counseling, 12-step recovery work, or a recovery support group. During my treatment with buprenorphine, I agree to seek additional counseling and to work on a program of recovery.

2. I agree that my physician can coordinate my medication switch with the provider of another opiate medication. This may involve exchange of medical records and discussions with the clinic physician or staff. After switching to buprenorphine, I will not take any other opiate medication.

3. I understand that on the day I start buprenorphine, I should already be in opiate withdrawal. The day before induction, I will not use any opiate (heroin, methadone, codeine or other opiate containing medications). If I am not having observable signs of opiate withdrawal, induction onto buprenorphine may be delayed a day or more.

4. I understand that I may not use any drug of abuse, legal or illegal. I understand if I use a drug of abuse, this could be cause for immediate termination from treatment.

5. I understand that my first dose of buprenorphine will be 4mg. After a couple of hours, I may be administered additional doses of buprenorphine, but will not exceed the dose prescribed.

6. I agree to take buprenorphine as prescribed by my physician, and will not allow anyone else to take medication prescribed for me.

7. I agree not to take other controlled medications with buprenorphine without prior permission from my doctor (examples include: Valium, Klonopin, Ativan, etc). I understand that overdose deaths have occurred when patients have taken other medications (particularly medications like Librium, Valium or other benzodiazepines) with buprenorphine.

8. I understand that buprenorphine itself is an opiate drug and can produce physical dependence that is similar to other opiates.

9. I understand that the goal of treatment of opiate dependency is to learn to live without abuse of drugs. Buprenorphine treatment should continue as long as necessary to prevent relapse to opiate abuse/dependence.

10. I agree to submit to periodic random observed urine drug tests, which will include buprenorphine. If buprenorphine is not present or other drugs of abuse are present, I understand that therapy from this office may be discontinued.

11. I understand that buprenorphine will be prescribed in quantities to last from visit to visit. The frequency of visits depends on how I am progress.

12. I understand lost prescriptions or buprenorphine tablets are a serious issue and may result in discontinuation of buprenorphine therapy from this office.

13. (Women of childbearing potential) I agree to tell my physician if I become pregnant or even think I may be pregnant.

14. I agree to random periodic buprenorphine "call backs." This will involve bringing my prescription supply to the office to determine if the appropriate number of tablets remain.

15. I understand that my prescription usage, including controlled medications by other physicians, will be monitored by the Oklahoma Bureau of Narcotics using the Oklahoma Prescription Monitoring Program.

I have read and understand these details about buprenorphine treatment. I wish to be treated with buprenorphine.

Signature of patient: _____Date: _____

Signature of provider: _____ Date: _____