Nebraska Medicaid and Long-Term Care Informed Consent Form for Treatment of Opioid Use Disorder To be completed upon initiation of therapy with Buprenorphine/Naloxone or Buprenorphine

This agreement tells you about your treatment for Opioid Use Disorder. You and your doctor/health care provider must follow state and federal regulations about the prescription of controlled substances.

I will begin treatment for OPIOID USE DISORDER. This treatment is designed to keep me free of drugs that can be abused. It is an essential step toward becoming drug free. By signing this document I acknowledge that:

1. The drugs used for treatment are controlled substances. They are regulated by local, state and federal authorities. It is a felony to get these drugs without a prescription or to give or sell them to anyone.

2. I will not ask for controlled drug prescriptions from any other prescriber. Doing so would risk the end of my treatment.
    a. I will tell my doctor about all drugs I am taking, including anxiety drugs, pain drugs, cough syrup and alcohol. Substances like these are not allowed during treatment.
    b. It is dangerous to mix my medication with other controlled pain prescription drugs. This includes benzodiazepines, such as lorazepam (Ativan), diazepam (Valium), temazepam (Restoril), and clonazepam (Klonopin). It also includes tramadol.

3. I will not use alcohol or illicit drugs during treatment.
    a. It is dangerous to mix my medication with alcohol or illegal drugs such as cocaine or marijuana.
    b. Doing so could change my treatment plan. This includes safe stoppage of my drugs and/or ending the doctor-patient relationship.

4. I will take the medication only as prescribed.
    a. I will not adjust the dose on my own. The goal is to reduce total daily dosage.
    b. Increasing my dose without the supervision of my doctor could lead to overdose. It is considered misuse.
    c. I will keep both the prescription and the medication safe so they are not misplaced, lost or misused by others. Lost or stolen medication will not be replaced.

5. I will get counseling while being treated.
    a. I must get all the counseling information and paperwork. I will get proof that I attended these sessions.
    b. I will comply with all my drug screens and drug counts.

6. My pharmacy is:
    a. Address: _____
    b. Phone number: _____

7. I will try a different type of treatment for Opioid Use Disorder if I fail to follow this contract or fail to meet Nebraska Medicaid's rules and want to continue treatment.

8. I allow my doctor and my pharmacy to cooperate with any city, state or federal law enforcement agency, as well as the state, in studying any possible misuse, sale or diversion of medication. My doctor can provide a copy of this agreement to my pharmacy.

9. I know about the side effects of taking my medication. Side effects include but are not limited to headache, insomnia, digestive issues, sweating and weakness. Many drugs used in Opioid Use Disorder produce physical dependence of the opioid type, which can cause withdrawal signs and symptoms at the reduction or end of treatment.

10. I will tell my current doctor if I previously used a drug for Opioid Use Disorder. My previous doctor's name was: _____

11. I will follow all of these guidelines. My questions and concerns about this treatment have been adequately answered. I have a copy of this document.

I acknowledge I have read the above information. Failure to abide by this agreement may cause my treatment to end.

PATIENT PRINTED NAME: _____

SIGNATURE: _____

DATE: _____

Please FAX COMPLETED FORM TO WellCare at 1-877-276-9630.