SICKLE CELL DISEASE PLAN
OF CARE AGREEMENT

Your Sickle Cell Center physicians know that sickle cell disease creates very difficult challenges for patients afflicted with the disease. Their overriding goal is to safely address these challenges and effectively treat your condition. This agreement is meant to help them do so by facilitating communication about your pain medications and their use. This agreement is also meant to prevent misunderstandings. Because pain medications carry a high risk of abuse, your physicians need to carefully monitor their use. For that reason it is important that you take your pain medications as directed and accurately notify your physicians of their effect. You should also follow any other directions your physicians give you for managing your pain. In return for these actions your physicians will address any medication-related challenges you experience on a case-by-case basis with the above-mentioned challenges in mind.

I, _____, understand and agree with the following:

1. My sickle cell disease doctor has explained long term opioid (pain medicine) therapy to me. This explanation has included other forms of therapy, the risks of this therapy, and the benefits that I may have. I understand that the benefits are not always guaranteed.
2. For women: The sickle cell disease doctors recommend that I use birth control. If I have questions about birth control or become pregnant, I will contact a doctor who manages pregnancy. I can ask the Sickle Cell Center to help me find such a doctor.
3. I will talk to my sickle cell disease doctor about pain, how the pain affects my life, and how the medicine is helping my pain.
4. I have the right to stop taking a medication, but I must discuss this with my sickle cell disease doctor first.
5. I will obtain <u>all</u> opioid (pain medicine) prescriptions from the Sickle Cell Center doctors, except short term prescriptions following hospital or emergency department visits. I realize my primary doctor and the doctor who referred me will receive a copy of this agreement and that my Sickle Cell Center doctors will talk with them whenever necessary.
6. I will use only <u>one</u> pharmacy to fill my opioid (pain medicine) prescriptions.
7. I will <u>not</u> share my medication with anyone.
8. I will guard my pain mediation from loss or theft. Lost or stolen medications will not be replaced.
9. I agree that refills of my prescriptions for pain medications will be made <u>only</u> at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.
10. I agree that I will complete a blood or urine test if needed by the Sickle Cell Center.
11. I agree to take this medication as written and not to change the amount of or how often I take the medication without talking with the prescribing doctor. Running out of medication early, needing refills early, increases doses of medication without permission, and losing prescriptions may be signs of misuse of the medication and may be reasons for the doctor to discontinue prescribing medications to me.
12. I understand that if I break this Agreement, my doctor may stop prescribing these pain control medicines.
13. In this case, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

14. I agree that I will attend all required follow-up visits with the doctor to monitor this medication. When I am unable to keep my appointment, I will call as soon as possible to tell the appropriate person. I understand that not doing so will result in stopping of this treatment. I also agree to participate in other chronic pain treatment services recommended by my doctor.

15. I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my pain medication. I authorize my doctor to provide a copy of this Agreement to my pharmacy and primary care physician.

A copy of this document has been given to me. This Agreement is entered into on this ____ day of _____, 20_____.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____