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.

The purpose of this agreement is to give you information about the medications you will be taking for the treatment of Opioid Use Disorder and to assure that you and your doctor/health care provider follow all state and federal regulations concerning the prescribing of controlled substances.

I have agreed to begin treatment for OPIOID USE DISORDER. I understand that the purpose of this treatment is to keep me free of abusable-type drugs. This agreement is essential to ensuring I have a successful attempt at becoming drug free. By signing this document I acknowledge that:

1. I understand the medications used for treatment are still controlled substances. They are highly regulated by local, state, and federal authorities.
   a. I understand that it is a felony to acquire these medications inappropriately without a prescription or to give or sell them to anyone.

2. I will not request other controlled medication prescriptions from any other prescriber and by doing so I risk termination of treatment.
   a. I will inform my doctor of all medications I am taking, including anxiety medications, pain medications, cough syrups, and alcohol. Medications like these can interact with my medication and are not allowed during treatment.
   b. I acknowledge that mixing this medication with other controlled pain prescription medications, benzodiazepines, such as lorazapam (Ativan), diazepam (Valium), temazepam (Restoril), or clonazepam (Klonopin), tramadol, alcohol, or illicit drugs can be dangerous and is not allowed during treatment.
   c. I will not use any illegal substances, such as cocaine, marijuana, etc. while taking this medication. This may result in a change to my treatment plan, including safe discontinuation of my medications or complete termination of the doctor /patient relationship.

3. I agree to take the medication only as prescribed.
   a. I will not adjust the dose on my own and the eventual goal is to be titrated down in total daily dosage.
   b. I understand that increasing my dose or taking more than is prescribed without the close supervision of my doctor could lead to overdose and is considered misuse of medication.
   c. I take full responsibility to secure both the prescription and the medication safely so that they are not misplaced, lost, or misused by others. Lost or stolen medication will not be replaced.

4. I agree to participate in counseling while being treated.
   a. It is my responsibility to get all the information and any needed paperwork regarding my counseling. I will provide adequate proof that I attended these sessions.
   b. I agree to be compliant with all my drug screens and drug counts.

5. The pharmacy I will use will be:
   a. Located at: _____

   b. Telephone number: _____

6. I agree to try a different type of treatment for Opioid Use Disorder if I fail to follow this contract or fail to meet Nebraska Medicaid's requirements and still want to continue treatment.

7. I authorize my doctor and my pharmacy to fully cooperate with any city, state, or federal law-enforcement agency, as well as the state in the investigation of any possible misuse, sale or diversion of medication. I authorize my doctor to provide a copy of this agreement to my pharmacy.

8. I am aware of the side effects of taking my medication. This medication can produce side effects including, but not limited to, headache, insomnia, digestive issues, sweating, or weakness. Many of the drugs used in Opioid Use Disorder produce physical dependence of the opioid type, characterized by withdrawal signs and symptoms upon discontinuation or taper.

9. If I have used a drug before for treatment of Opioid Use Disorder, I will let my current doctor know of my previous attempt(s) and have indicated the doctors seen previously here:_____

10. I agree to follow these guidelines that have been fully explained to me. All my questions and concerns regarding this treatment have been adequately answered and a copy of this document has been given to me.

By signing this document, I acknowledge I have read the above information, that I will abide by all parts of it and that failure to do so may result in my medication being discontinued.

PATIENT PRINTED NAME: _____

SIGNATURE: _____

DATE: _____

Submit requests to: Magellan Medicaid Administration, Inc. Fax: 1-866-759-4115
Tel: 1-800-241-8335