

# Medications for Opioid Use Disorder (MOUD) Patient-Provider Agreement

[SAMPLE]

I understand the following information has been discussed with me to ensure my safety and I have had opportunity to participate in shared decision making, including asking any questions I may have:

1. **I will keep my medication in a secure place** away from children (e.g., in a lock box). I will immediately report any lost/stolen/missing medication to my provider. I understand that a higher level of care or additional stabilization may be discussed if my provider deems appropriate.
2. **I will take the medication as prescribed.** If I want to change my medication dose, I will speak with the provider first. I understand changing my dose or ingesting it in ways other than prescribed may necessitate referral to a higher level of care for my safety.
3. **I will keep my provider informed of all my medications** (including herbs and vitamins) and medical problems. I understand it is important for me to discuss any plans to engage in any other opioid treatment while under this provider's care for same.
4. **If I am going to have a medical procedure that will cause pain**, I will let my primary care provider, the provider conducting the medical procedure, and any other provider involved in my healthcare know in advance so that my pain can be adequately treated.
5. **I understand that I may be asked to provide scheduled or random drug screens** to determine if the treatment protocol is beneficial for me. I will discuss any concerns around this with my provider.
6. **I understand that I could be called at random times to bring my medication to the office for a medication count.**
7. **I understand my provider will work with me to develop an individualized treatment plan.** This may involve weekly, twice a month or monthly visits depending on my stability and disease severity.
8. **I understand that people have died by mixing buprenorphine with other drugs** like alcohol and benzodiazepines (drugs like Valium®, Klonopin® or Xanax®). I agree that I will avoid alcohol or take any benzodiazepines not prescribed while prescribed buprenorphine by my provider.
9. **I understand that treatment of opioid use disorder may involve additional modalities beyond medication.** I will remain open-minded to these discussions with my provider and consider how they may benefit my well-being.
10. **I understand that there is no fixed time for being on buprenorphine** and that the goal of treatment is to stop using all illicit drugs and become successful in all aspects of my life.
11. **I understand that I will develop a physiological dependence on buprenorphine**, meaning I will need to take the medication every day. I will experience opioid withdrawal symptoms and cravings when I go off buprenorphine, and I will discuss with my provider a plan to minimize these symptoms.
12. **I have been educated about other options** of FDA-approved medications for opioid use disorder treatment, methadone and naltrexone. Together with my provider, we have agreed that at this time, buprenorphine is the best option for me.
13. **If biologically female and of child-bearing years,**
  - **I have been educated about the increased chance of pregnancy** when stopping illicit opioid use and starting buprenorphine treatment and offered methods for preventing pregnancy.
  - **I have been educated about the effects of MOUD during pregnancy** and how these things can adversely affect my health and my current or future fetus/newborn's health. I understand that neonatal abstinence syndrome can occur when taking illicit opioids and that neonatal opioid withdrawal syndrome (NOWS) is less severe, but can still occur, when methadone or buprenorphine is taken during pregnancy, even if taken as prescribed/dispensed in substance use disorder treatment.
14. Other specific items unique to my treatment include:

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PATIENT NAME (PRINT)

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PATIENT SIGNATURE

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DATE

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PROVIDER NAME (PRINT)

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PROVIDER SIGNATURE

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DATE