Medication Management Agreement

Provider: Please complete this Medication Management Agreement with your Alliance member, and fax a copy to the Alliance at **1-877-793-8504**.

Member name: _____

Date of birth:_____ Alliance ID#:_____

I understand that:

- Medicine to manage my pain is being ordered by my doctor to allow me to do things that I can't do now because of pain. These things include: _____

_____

- Pain medicine may make my pain better but may not take away all of my pain.
- My doctor may change or stop my pain medicine if it doesn't help me do the things I can't do now.
- There is a risk that I could get addicted to pain medicine. If this happens or if I am not using the medicine astold, my doctor may stop giving it to me.

I will:

- Only get my pain medicine from _____'s office and from _____ pharmacy.
- Take the pain medicine exactly as directed by my doctor.
- Allow my doctor to talk with other doctors about my health problems.
- Only ask for refills during an office visit (Monday to Friday from 8:00 am to 5:00 pm).
- Tell my doctor if I get pain medicine from another doctor or the emergency room.
- Keep my pain medicine in a safe place AND away from children.
- Allow my doctor to check my urine (pee) or blood to see what other medicines or drugs I am taking.
- Bring all pain medicine I haven't taken yet to every office visit, if my doctor asks me to.

The medicines covered by this agreement include **(Please print clearly):**

Medicines	Dose	How I Take It	Amount Per Month

I will NOT:

- Use someone else's medicine, share, sell, or trade my pain medicine with anyone.
- Use illegal drugs (such as crystal meth, heroin, cocaine, etc.).
- Change how I take my medicine without asking my doctor.
- Ask my doctor for extra refills if I use my supply or lose my medicine before my next visit with my doctor.

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I understand that if I do not follow these rules, my doctor:

- Will stop prescribing pain medicine for me and may ask me to see another doctor for my care.
- May refer me to a drug or alcohol abuse treatment program.

Member signature: _____ Date: _____

Provider name: _____

Practice NPI: _____ Rendering Provider NPI: _____

Provider signature: _____ Date:_____