Clinton County Medical Center
1055 S US 27, St. Johns MI, 48879
Phone: (989) 224-3000
Fax: (989) 224-1424

Patient: _____________________________ Date: _____________________

SUBOXONE REGULATIONS
I AM SIGNING HERE TO INDICATE THAT I WILL ACTUALLY READ ALL OF THE BELOW BEFORE INITIALLING

SIGN__________________________________WITNESS___________________________

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THE PURPOSE OF SIGNING THIS FORM IS TO RE-INFORM YOU OF THE ALREADY EXISTING RULES AND REGULATIONS BY WHICH WE DISPENSE AND PRESCRIBE SUBOXONE MEDICATIONS. WE DO THIS BECAUSE PATIENTS MAY AT TIMES FORGET AND WE WOULD LIKE TO MAKE THE PROCESS AS SEEMLESS AS POSSIBLE.

I HAVE BEEN LICENSED BY THE STATE OF MICHIGAN AND THE DEA (DRUG ENFORCEMENT AGENCY) TO PROVIDE SUBOXONE TO PATIENTS FOR THE TREATMENT OF OPIOD DEPENDENCE, PRACTICING ADDICTION MEDICINE REQUIRES A SPECIALIZED GOVERNMENT LICENSE AND ALTHOUGH IT IS IN EVERYONES INTEREST TO TREAT AS MANY PATIENTS AS WE CAN FOR THIS PROBLEM, THE GOVERNMENT HAS PUT INTO PLACE VERY STRICT RULES, THESE DEA REGULATIONS ARE SO RIGID THAT I MUST OBSERVE THEM IN ORDER TO PROVIDE YOU WITH THIS MEDICATION. I WILL ADHERE TO THESE RULES IN ORDER TO MAINTAIN COMPLIANCE.

PLEASE DO NOT ASK FOR EXCEPTIONS AS THEY WILL NOT BE GRANTED.

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-You may NOT make any adjustment to your Suboxone without my prior approval. Doing so may cause discharge from the program. **Initial_______**

-You must make office visits as directed by your physician, no exceptions, for all refills. DEA requires this. **Initial_______**

-We will under NO circumstance EVER prescribe more than ONE month's worth of medication ever. We do not send prescriptions to ANY mail-away prescription service. **Initial_______**

-If you fail to show for 3 office visits, you may be discharged from the program. There are too many patients waiting in line that really want this treatment. You must be serious and committed to this cause and demonstrate this. **Initial_______**

-Please do not call in the last minute when you run out of medications and expect us to get you in anytime. Please plan accordingly. Withdrawals are not fun so please plan ahead. We can accommodate your needs almost anytime, but maybe not in the last minute. **Initial_______**

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-We will follow-up with you as needed to make adjustments to your medications regimen. If deemed necessary, we will call you back for any issues. We will only call back after hours if it is truly needed for the purpose of adjustments. Do not expect call after hours or weekends unless it's an emergency. **Please note that losing your medicine is not an emergency.**
Initial_______

-Guard your medications like your cash. They will NOT be refilled. If you lose them or if they are stolen, you will go thru withdrawal until your next refill. This will not be fun. Guard them extremely well. The DEA doesn't care about why you lost it.
Initial_______

-We are obligated by the DEA to do random urine drug tests. I will ask you what other drugs I will find on the urine test before doing this. Additional drug use or non-compliance will lead to termination at my discretion. I never judge patients for relapses but I do expect honesty and compliance and an effort at remaining drug free. If you fail a drug test expect to give me a written explanation that I can log for the DEA so I can even consider continuing you on Suboxone. **Initial**_______

-We expect you to understand (and sign) that you realize that Suboxone is a form of narcotic and that if you drive any vehicle (motor or otherwise) you may cause accidents that can harm or kill you or others. In addition, you may be charged with a DUI if you drive while on any narcotic including Suboxone. We are telling you here and now that you may NOT drive within 12 hours of taking Suboxone. If you feel you can drive safely, that is your choice but it is against our medical advice. **Initial**_______

-You will NOT share this medication with anyone else EVER. If you do, we will discharge you immediately and we are obligated to report this to the police and the DEA as this puts providers at CCMC profession and license on the line. This will not be tolerated, even once. **Initial**_______

-We may request random urine testing throughout the program. If we call you to drop off a urine specimen, We will expect a sample within 12 – 24 hours. We must do this to prove to the DEA that we are in compliance. If you fail to provide the requested samples as directed, you may be discharged from the program. **Initial**_______

-Please note that it is your responsibility to check with your insurance and see if they will pay for Suboxone. A few insurance require prior authorizations. If your insurance requires a prior authorization, you will be required to schedule a visit with the nurse in order for the prior authorization to be completed. **Initial**_______

-SIGNING BELOW INDICATES THAT I HAVE READ EVERY LINE ITEM ABOVE, UNDERSTAND THE WRITTEN ENGLISH LANGUAGE AND HAVE HAD A CHANCE TO ASK QUESTIONS ABOUT EVERY ITEM. YOU UNDERSTAND THAT AT ANYTIME IF YOU HAVE ANY QUESTIONS AT ALL ABOUT THESE REGULATIONS YOU MAY CALL OUR OFFICE AT 989-224-3000 AND GET AN ANSWER.

Patient Name: ____ Date: ____________________

Patient Signature: ____

Physician Name: ____

Physician Signature: ____