As your healthcare professional who will be treating your pain, I believe methadone is an appropriate treatment for you. Methadone can be helpful in treating pain if used correctly, but if you do not take it exactly as I will prescribe it for you, it can be very dangerous and may seriously harm you. By signing this agreement you are agreeing to follow all of the policies on how to take your methadone to treat your pain and how to properly store it.

Most Important Information  Please initial in each box.

☐ My healthcare professional has explained and I understand the risks and benefits of using methadone to treat my pain.

☐ I have read the patient information for methadone.

☐ I understand that methadone can cause life-threatening heartbeat problems that can lead to death.

☐ I understand that methadone can cause life-threatening breathing problems and that sometimes these breathing problems will happen a while after taking a dose, even after my pain has returned.

☐ I will not take a higher dose of methadone or take it more often than prescribed, as this can lead to an overdose or possibly death.

☐ I understand that methadone should not be used to treat breakthrough pain or pain that I have once in a while.

☐ I will only take my methadone for my pain and not to help me sleep or to reduce stress.

☐ I understand that methadone affects every person differently and that pain relief can last 4 to 8 hours.

☐ I understand that it can take 3 to 5 days from the first dose for methadone to reach its full pain-relieving effects, although for some people it can take as long as 12 days.

☐ I understand that each dose of methadone can stay in my body for over one week and that it can continue to affect my breathing and heartbeat even after its pain-relieving effects have worn off.

Getting My Medication  Please initial in each box.

☐ I will tell my healthcare professional immediately about any new medications or medical conditions and about any side effects I experience for any medications I take.

☐ I will only get my prescription pain medication(s), including methadone, from my healthcare professional whose signature appears in this document unless he or she tells me that another healthcare professional will write my prescription.

☐ I will always get my methadone prescriptions and other prescription pain medicines filled at the same pharmacy, and if I need to change pharmacies, I will immediately inform my healthcare professional.

The pharmacy I will use is: _________________________________  Phone: ______________________________
I will participate in counseling about my medicines with my pharmacist.

I will bring my original container of methadone with me to every office visit.

I understand that my methadone may not be replaced if it is lost, damaged, or destroyed.

I understand that early refills may not be given.

If I receive a prescription for my methadone before the refill is due, I will not refill my prescription until the date shown on the prescription.

I understand that if I fail to follow any part of this agreement, my healthcare professional may stop prescribing me methadone and/or refer me to a specialist for further assessment.

I will keep my scheduled appointments as a requirement to renew my methadone prescriptions.

I give my healthcare professional permission to discuss my diagnosis and treatment with my pharmacist and other healthcare providers.

I will allow my healthcare professional to perform urine and blood tests as needed to monitor my treatment.

I understand that if there are illegal substances in my urine or blood, my healthcare professional may promptly refer me to check if I am addicted to illegal drugs.

I understand my healthcare professional will likely start me on a low dose of methadone and then slowly increase my dose depending on how I react to the medicine.

I will tell my healthcare professional if my pain is not better at the prescribed methadone dose, and I will not change my dose unless and until I am told to do so by my healthcare professional.

I will tell my healthcare professional if I have or if I develop trouble breathing; if I have extreme drowsiness or sleepiness and my breathing slows down; if I develop shallow breathing, fast or slow heart rate, or an irregular heartbeat; if I feel faint, become dizzy, or become confused, or if I have any other unusual symptoms, including if I am or become allergic to methadone or anything else in methadone tablets.

I understand that if my treatment with methadone does not treat my pain, my healthcare professional may stop my treatment with methadone.

Safe Use  Please initial in each box.

I will take my methadone exactly as prescribed and follow my healthcare professional's directions exactly. I will not take more than my prescribed daily dose or take it more often than prescribed.

I have told my healthcare professional about all of the medicines I currently take, including medicines that may make me drowsy or sleepy, such as other medicines to treat depression (antidepressants), other pain medicines, sleeping pills (hypnotics), medicines to treat anxiety (anxiolytics), cold and allergy medicines (antihistamines), or medicine to help calm me down (tranquilizers).

I understand that taking other medications that cause drowsiness or sleepiness (sedation) while I am taking methadone can cause life-threatening health problems including trouble breathing, low blood pressure, profound sedation (excessive sleepiness), or coma. This includes other medicines to treat depression (antidepressants), other pain medicines, sleeping pills (hypnotics), medicines to treat anxiety (anxiolytics), cold and allergy medicines (antihistamines), or medicine to help calm me down (tranquilizers).
I will not take any new medicine, including non-prescription medicine, vitamins, and herbal supplements, until I have first talked with my healthcare professional.

I understand that mixing methadone and alcohol is a dangerous combination and could lead to death; therefore, I will not drink alcohol when taking my methadone.

I will not abruptly stop taking my methadone regularly, as directed by my healthcare professional, without talking to him or her first.

Proper Handling and Disposal  *Please initial in each box.*

☐ If a child takes my methadone, accidentally or on purpose, this is very serious and can kill them. If a child takes methadone, I will get emergency help right away by calling an ambulance or 911, even if the child is not experiencing any side effects.

☐ I will keep my methadone in a safe place, out of the reach of children and protected from theft.

☐ I will never give or sell my methadone to anyone else, even if they have the same symptoms I have. It may harm them, and it is against the law.

☐ I understand that if I stop taking my methadone, I should flush any unused tablets down the toilet.

Understanding This Agreement  *Please initial in each box.*

☐ I have asked my healthcare professional all of the questions I have about using my methadone, and I understand all of the answers I was told.

☐ I have read and understand this agreement, and I understand that I must follow every part of this agreement.

☐ If I have additional questions about methadone, or how to take methadone or store my prescription, I will ask my healthcare professional or pharmacist.

Healthcare professional name (printed)

Healthcare professional signature  Date

Patient name (printed)

Patient signature  Date