

Opioid Taper Agreement

The opioid taper agreement outlined below was formulated following a discussion between the patient and provider in where both parties decided to gradually discontinue opioid therapy as the benefits of therapy no longer outweigh the risks. The opioid taper will begin on _____ and is planned to end on _____.

| Patient's Initials | Terms of Agreement |
|--------------------|--|
| | I agree to attend all regularly scheduled appointments, treatments, and consultations as requested by my provider, and comply with other pain consultations and management strategies as necessary. I consent to open communication between my provider and any other healthcare professional involved in my pain management, such as pharmacists, other physicians, emergency departments, etc. |
| | I will only request and receive opiate (narcotic) pain medications and any other controlled substances from the provider whose name is listed below, or from their designee in clinic. I will not request pain medications from other doctors in any network. I agree to inform any other providers participating in my care of this agreement. I must obtain all controlled substance prescriptions from the same pharmacy. Should the need arise to change pharmacies, I will inform my provider. I have selected the following pharmacy as my pharmacy of choice and agree to fill all my controlled substance prescriptions here: _____ |
| | I understand that my urine may be tested for controlled substances throughout the taper and that random urine follow-up testing may be done. I agree to cooperate in such testing and understand that the presence of any unauthorized substances, illicit substances, or the absence of prescribed medications may prompt referral for assessment of addictive disorder and discontinuation of the controlled substances immediately. I understand that my provider will perform regular prescription drug monitoring program checks to ensure the correct and routine use of my controlled substance medications throughout the taper. |
| | I will notify my provider of any additional factors, such as the development of increasing depression symptoms, that may negatively impact the tapering process and act as a barrier to success. I understand that I must contact my provider immediately to discuss discontinuation or changes in the tapering plan should any issue occur. I agree to notify my provider of any new medication or medical conditions I acquire during the taper. |
| | I may not share, sell or otherwise permit others to have access to these medications. I must take all medications exactly as prescribed, unless I develop side effects. I understand that I must keep all controlled substances in a secure area. Since these medications may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, I must keep them out of reach of such people. |
| | I agree to engage in relevant pain management strategies concurrent with the taper, such as multidisciplinary functional restoration programs, physical therapy, or psychological counseling, as deemed necessary by my provider. I agree to actively involve my significant other, a family member, or close friend where appropriate to provide me with support and encouragement during my taper. |

Adapted from: Berna C, Kulich RJ, and Rathmell JP. Tapering Long-Term Opioid Therapy in Chronic Non-Cancer Pain: Evidence and Recommendations for Everyday Practice. *Mayo Clinic Proceedings*. June 2015; 90(6): 828-842.



ESHELMAN SCHOOL OF PHARMACY



SCHOOL OF MEDICINE
Center for Aging and Health

Weekly/Monthly Reduction Plan

Week/Month #1:

Week/Month #2:

Week/Month #3:

Potential Risks of Opioid Discontinuation

Withdrawal Symptoms:

Fluctuations in Pain

Increased Anxiety

Provisions for Opioid Taper Failure

In the event of a taper failure, I agree to explore one or more of the following after discussing the best course of treatment with my provider:

- Attempt a new taper with a revised dosing schedule
- Undergo referral to a structured inpatient taper
- Undergo referral for consultation with addiction medication or cognitive therapy specialists
- Discontinue use of opioid prescriptions, discontinue use of other specific medication prescriptions, or allow no more prescriptions above a certain dose beyond date _____
- Long-term maintenance opioid therapy (with current or other prescriber) – may include a specific substance or maximum dose

Patient Signature: _____

Date: _____

Print Name: _____

Provider Name: _____

Witness: _____

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