INTERMED
Care without compromise.

Stimulant Medication Agreement

We have discussed treating you/your child on a stimulant medication. This document outlines the expectations for patients, families, and providers when stimulants are prescribed. Most importantly, to ensure you are getting the best care possible, we will need your active participation and honest feedback on the effects of the medication(s). If you have questions or concerns about your treatment, please share them.

I/my child: _____ Date of Birth: _____,

have agreed to use the medication: _____ as part of my/my child's

treatment for a diagnosis of: _____.

I am aware that the use of stimulant medications has certain risks and side effects, including but not limited to:

- Decreased appetite
- Trouble sleeping
- Headaches
- Aggressive behavior and/or agitation
- Psychosis and/or mania
- Increased heart rate
- Anxiety
- Exaggerated emotional changes

I agree to the following:

1. I am responsible for my/my child's medications. I will not share, sell, or trade my/my child's medication. I/my child will not take anyone else's medications.

2. I will not increase or change how my/my child's medication is taken until I speak with my provider.

3. My/my child's medication may not be replaced if it is lost, stolen, or used up sooner than prescribed.

4. I consent to random drug screenings for myself/my child, to assure I/my child is only taking prescribed drugs. I understand that all out-of-pocket expenses associated with drug screenings will be my responsibility.

5. If an inventory check (pill count) is requested, I will bring my/my child's medication, in the original container, to InterMed at the requested time so that the clinical staff may verify the amount of medication.

6. I agree that the monitoring and refilling of the medication will be conducted by my/my child's provider in office visits at regular intervals.

7. I will notify my/my child's provider if I/my child is prescribed a controlled substance medication by another provider.

Patient Initials _____

8. I will notify my/my child's provider if I/my child become(s) pregnant because stimulants pose risks to the fetus during pregnancy and lactation.

9. I will not place calls to the office staff with demands for variations or exceptions to the contract.

10. I will not be disrespectful, use profanity, or harass the office staff, and I understand that doing so could be grounds for discharge from InterMed.

11. Renewals are contingent upon me/my child keeping scheduled appointments and following prescription directions.

12. I understand that my/my child's prescribing provider will want to review my stimulant agreement with me/my child annually, or sooner if indicated, during an office visit. I will participate fully and honestly with such a review for the reactivation of the agreement/consent.

13. I understand that my provider will verify that I/my child is receiving only the stimulants I reported previously and only from prescribers that were previously reported by checking the Maine Prescription Monitoring Program website as required by law.

14. I understand that I can only fill the stimulant prescriptions at a pharmacy located in Maine unless an out-of-state pharmacy is agreed to by the prescribing physician.

15. I will not request stimulants or controlled substances from other providers, including any emergency room (ER) without also notifying my/my child's prescribing provider at InterMed. I understand that other providers should not change the dose of my/my child's stimulant, and I will notify my/my child's provider of any changes to my/my child's medications made by another provider and the reason for the change.

16. I will inform my/my child's other healthcare providers, including ER providers, that I am/my child is taking a stimulant(s) and that I have signed a stimulant contract with the physician listed below.

17. I will inform my/my child's provider of all other medications and substances I/my child is taking, to include over the counter, herbal, and prescribed medications, as well as past and present use/misuse of alcohol and substances (illicit, recreational, street drugs).

18. I was advised by my/my child's provider that alcohol and substance use are not recommended with this medication, and their use can cause serious side effects, including life-threatening reactions, when used alone and/or in combination with this medication.

19. I am aware that if I/my child is found to be using illegal substances (e.g., cocaine) my/my child's provider may stop prescribing this medication.

20. I/my child will not use another person's prescriptions.

21. I will inform my/my child's provider of any new medications or medical conditions, including ER treatment or pregnancy.

22. I/my child will participate in any medical, psychological, or psychiatric assessments or treatment programs designed to improve the safety and benefit of the stimulant treatment plan as recommended by my/my child's provider.

23. The use of substances of abuse while taking stimulants can be unsafe and may interfere with the benefit of the medication. Please notify your/your child's provider of any known or suspected substance use.

Refills:

1. Timely requests (at least three business days) for refills are my/my child's responsibility. Refill requests will be made by phone or via the patient portal Monday through Friday. Refill requests won't be processed on nights, weekends, or holidays.

2. My/my child's provider may send a prescription to my/my child's pharmacy before the day the refill is due, but the prescription cannot be filled until the 'do not fill until' date on the prescription, which is determined by the provider, last refill date, Maine state law, and/or pharmacist.

3. I will not ask for refills earlier than the prescribed interval. Lost or misplaced prescriptions will not be replaced.

4. I will keep my/my child's medications and prescriptions in a secure, safe place, preventing others' access to these medications.

5. If my/my child's medication is stolen, a copy of the police report must be given to my/my child's provider for replacement to be considered.

I understand that my/my child's provider may STOP prescribing my/my child's stimulant if:

1. I/my child does not show any symptom improvement.

2. I/my child does not fulfill the responsibilities above.

3. I/my child misses two consecutively scheduled appointments associated with the stimulant medication or related condition(s).

4. My/my child's provider determines that the harms of this medication outweigh the benefits, this medication may be stopped by my/my child's provider in a safe way.

5. I/my child refuses to consent to a drug screening, or I/my child is found to be using illegal substances (e.g., cocaine) or controlled medications prescribed by another provider or obtained illegally.

Provider Responsibility:

1. This agreement is intended for patients with an established or anticipated chronic use of a stimulant medication, defined as 90 or more days of use in a 12-month period.

2. We will discuss additional forms of treatment to help with you/your child's condition.

3. We may need to contact other providers or family members to get information about you/your child's care and/or use of this medication. We will ask you to sign an authorization for release of information if permission for communication is not already documented. We will work with any other providers that you/your child is seeing so that they can treat you safely and effectively.

I have had an opportunity to read the above agreement and consent or have had it read to me. I have had my questions answered to my satisfaction. I understand and accept the risks, conditions, and terms of the proposed treatment as presented. I am signing this form voluntarily, and I have full right and power to be bound by this agreement.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(for patients under the age of 18)

Provider Signature: _____ Date: _____

Printed Name of Provider: _____

Cc: Primary Care Provider (if different than provider above): _____