Alberta College of Pharmacy

Pharmacy-patient agreement for OAT services

Pharmacists are encouraged to adapt this agreement to reflect their pharmacy's operations and the specific circumstances of their patient(s) more accurately. The information provided below is intended to provide a framework on which to build a site-specific pharmacy-patient agreement.

Patient name: _____

Pharmacy name: _____

Hours of operation: _____

You have been prescribed the following Opioid Agonist Therapy (OAT) for treatment of opioid use disorder (OUD):

- ☐ Methadone (Methadose®, Metadol-D®, generics)
- ☐ Buprenorphine-naloxone (Suboxone®, generics)
- ☐ Slow-release oral morphine (Kadian®)
- ☐ Other: _____

Our pharmacy will provide the pharmacy services you require as part of your treatment. The length of time you will need to take medication for OUD can vary, but in many cases, these medications are taken for months, years, or indefinitely.

As part of your treatment plan, a pharmacist may be required to observe you directly as you ingest your medication. This is done for your safety, and so the pharmacist can monitor your progress closely and work with you to achieve your health goals. As such, you may be required to attend the pharmacy as frequently as once per day. Your pharmacist will work closely with your prescriber and observation will continue until your prescriber determines that take-home doses are safe and appropriate.

In order to assess the safety and effectiveness of your medication, your pharmacist may ask you questions about your ingestion of other substances, prescribed and non-prescribed. Pharmacists are knowledgeable in how these substances will impact your treatment. It is in your best interest to share this information openly with your pharmacist, as they will work with you and your prescriber to determine the best, and safest, course of action.

Your pharmacist will work together with your prescriber and other treatment team members as appropriate to support you. While following all applicable privacy laws, the pharmacist may consult with your OAT prescriber, your family doctor, or other members of your treatment team if health care concerns arise as you progress with your treatment. You are also encouraged to consult your prescriber, family doctor or pharmacist as needed if you have concerns about your health or your treatment.

This agreement is between

- you, our patient, and
- your pharmacy and its staff.

This agreement outlines responsibilities and obligations of each party to ensure a mutual understanding and awareness of the expectations involved in our collaboration. This agreement may be shared with your prescriber. You may ask to review this agreement at any time and are entitled to a copy of it.

Your pharmacy agrees to provide you with

- Professional services that prioritize respect and personal dignity.
- Access to trained professionals who are competent in OUD and OAT to address your questions and concerns.

- Professional expertise, skills, and knowledge about your treatment that will always have your best health interests in mind for decisions that are made.
- Privacy and confidentiality regarding your private health information. Your confidential information will only be shared with your consent on a need-to-know basis, or as required by law.
- Ongoing monitoring, support, and encouragement to maximize your health outcomes.
- Professional services until they are no longer required or wanted, or until another suitable pharmacist or other regulated health professional has assumed responsibility for your care.
- Reasonable notice if unable to continue providing you care.
- Respect for your decision to end treatment if you decide to do so.

Patient initial _____ Pharmacist initial _____

As the patient receiving OAT medication, I agree to

- Take my OAT medications as prescribed for my opioid use disorder.
- Let my pharmacist know if I am experiencing any unexpected or unpleasant effects of treatment.
- Make every effort to come to the pharmacy when I am to receive my OAT medication and call the pharmacy if I am going to be late. If I am not consistent with my dosing regimen, I am aware that my treatment may need to be adjusted for my safety. This may, in some cases, include discontinuing my prescription.
- Bring and show my photo ID to the pharmacy team as requested when I visit my pharmacy for my OAT medication dose.
- The pharmacy team calling my prescriber if they have any concerns about my safety on OAT.
- The pharmacy team contacting and collaborating with my prescriber if a dose is missed, lost, stolen, and/or partially administered.
- Call the local law enforcement, as well as my pharmacist and my prescriber, if I lose a dose or if a dose in my possession is stolen, as my medication may be dangerous to the community. Alternatively, I agree to allow the pharmacist to call local law enforcement and my prescriber on my behalf.
- Inform my pharmacy team and prescriber of any other medication that I am prescribed or taking, including natural health products and vitamins, as I realize that some treatments may interact with OAT medications and have the potential to cause harm to me.
- Complete laboratory or point-of-care tests (e.g., urine tests, electrocardiogram, or ECG, etc.) as directed by my prescriber or pharmacist, as these are necessary to monitor the safety and effectiveness of my treatment.
- Be polite and respectful of other patients and the pharmacy staff while on the premises of the pharmacy. Behaviour such as verbal or physical harm to others, criminal activity within the pharmacy, uttering profanities, or threats may result in restriction or discontinuation of services from the pharmacy.

Patient initial _____ Pharmacist initial _____

As the patient on OAT, I am aware that

- I must not drive or operate machinery that requires my alertness when I am being initiated on therapy (typically at least the first two weeks), when I am having doses adjusted, or if I am experiencing treatment effects that are making me sleepy or not alert.
- Taking narcotics, sleeping pills, alcohol, or other sedating substances may interact with my OAT to cause overdose, coma, or even death. I will not take other medications or substances unless my OAT prescriber and my OAT pharmacy are aware.
- The pharmacy will not provide me with my OAT medication if I arrive impaired by a medical condition or substances such as medications, drugs or alcohol, or if the pharmacist has any other reason to believe that it is not safe for me to take my OAT.

Patient initial _____ Pharmacist initial _____

Take-home doses (if applicable)

Your doctor has authorized us to provide you with take-home doses (carries) of your OAT medication that you can take yourself on selected days as indicated. OAT medication can be very dangerous to someone for whom it is not prescribed. Even small doses can harm or kill a child or pet. Some OAT can also be fatal to an adult if accidentally ingested.

You are responsible for properly securing and storing your OAT medication so that others cannot be harmed from an accidental exposure.

As a patient prescribed take-home doses of OAT, I agree to

- pick up my take-home doses in person and to show my valid identification to the pharmacist when I pick up the take-home doses;
- store my carries in a secure location, preferably a locked or secured container or enclosure. The pharmacist will advise me of any special storage instructions (e.g., refrigerator for diluted methadone or at room temperature in a locked cupboard for other forms of OAT);
- store and take the methadone in such a way that it cannot be accidentally ingested by anyone else;
- take my OAT medication as prescribed by my doctor and on the ingestion date that is specified on the label of each container;
- keep naloxone on hand at home or wherever I take my OAT dose;
- return all my OAT containers to the pharmacy with their original labels left intact for proper disposal; and
- call my doctor or my pharmacist if I have any withdrawal symptoms or side effects.

Patient initial _____ Pharmacist initial _____

I am aware of the following:

- For my personal safety, my pharmacist may call me to come in for an unscheduled assessment during the carry period. The pharmacist may ask me to bring in all my OAT containers, full or empty, at this time.
- My pharmacy will not replace lost, stolen, spoiled, spilled, or vomited doses.

- The side effects of my OAT that may be considered medical emergencies. I will go immediately to the hospital emergency room if I experience any of these side effects.
- How and when to administer naloxone if I experience any signs of opioid overdose.
- For my personal safety and for the safety of the public, take-home doses of methadone may only continue if I am responsible with the medication and if I remain clinically stable on the drug.

Patient initial _____ Pharmacist initial _____

Summation

Through this agreement, I have been made aware that, in Alberta, TPP Alberta monitors the prescribing and use of OAT and other narcotic prescriptions. This information will be recorded. This may involve occasional review of my file by an external reviewer working within the regulatory colleges for physicians or pharmacists to view my health files or the pharmacy's prescription files. I am aware this is a legal requirement that my prescriber and pharmacist do not control, and that it is part of the regular auditing and inspection process of their respective governing bodies. I understand that my personal health information may be shared in such circumstances as required by law.

_____ _____

Patient signature Pharmacy representative signature

Date _____ Date _____

Prescriber signature (optional)

As the patient's OAT prescriber, I acknowledge I have received a copy of this agreement.

_____

Prescriber signature

Date _____