Medication Contract Form

I,_______________________________________ agree to the following rules and conditions regarding refills of prescribed medications.

The medication(s) covered by this agreement are:

Medication	Dose	Directions	Quantity (per month)

1. I will limit my dose of medications to the dose prescribed. I will discuss any necessary changes in my dose with my provider.
2. I am responsible for my medications. I understand that lost, misplaced or stolen prescriptions will not be replaced.
3. Refills will be made only at the prescribed level. No early refills will be authorized.
4. No refills with be authorized after business hours, on holidays or on weekends.
5. I will fill all prescriptions and refills for these medications at this pharmacy:

   _______________________________________ Phone number: ________________________
6. I will request all refills from my primary care clinic (name).
7. I understand that my provider may stop prescribing opioids or change the treatment plan if I do not show improvements in pain from opioids or my physical activity has not improved.
8. Other: ____
9. I understand that if I do not comply with all of these conditions or do not keep regular follow-up appointments with my primary care provider that my prescriptions for the medications listed above may be terminated. I understand that if I do not comply with all conditions I may be prevented from receiving any further care.

Member: ____ **Date:** ______________________

Provider: ____ **Date:** ______________________