Medication Management Agreement

Provider: Please complete this Medication Management Agreement with your Alliance member, and then fax it to the Alliance at 877-793-8504.

Member name: ______________________ Date of birth: ______________

Member ID#: ______________________________________

I, ______________________, agree to the following rules about my controlled medications.

I am taking these medications to treat: ______________________________

The medications covered by this agreement include (please print clearly):

Medications	Dose	How I take it	Amount per month

1. I will take my medications as prescribed by my provider.
2. I will talk with my provider before changing my dose.
3. I will take care of my medications. My provider will not replace lost or stolen prescriptions.
4. My provider will not approve early refills.
5. My provider will not approve refills when the doctor's office is closed.
6. I request all refills by calling my provider during these hours: ______________________
   Provider's phone number: ______________________
7. I will get all refills for these medications at this pharmacy: ______________________
8. I know that my provider may change or stop my medications if they do not relieve my pain.
9. I agree that my provider may share this form with providers who are taking care of me, including emergency room providers and ______________________
   ____
10. I will see my provider every ______________________
11. I agree to follow the above rules. I understand that if I do not follow these rules, the provider may stop prescribing these medications. And if I break the rules, the provider may ask me to go elsewhere for care.

Member signature: ______________________ Date: ______________

Provider name (please print clearly): ______________________ Practice NPI: ______________

Provider signature: ______________________ Date: ______________