Park Avenue Medical, LLC
Anace Said, MD
Ursuala Hoxie, APRN
Juanita Dee, APRN

SUBLOCADE INJECTION TREATMENT CONTRACT

Patient Name: _____ **DOB:** ____/____/____

1. _____ I agree to keep and be on time to all my scheduled appointments. If I am late to my appointment I understand that I may not be seen and I will not receive my injection untill am able to be seen. I understand that I must call 24 hours prior to cancelling an appointment.
2. _____ I agree to adhere to the payment policies outlined by this office including all copays and **NO-SHOW** fees.
3. _____ I understand that I need to successfully be on a Buprenorphine containing medication for at least 7 days prior to having Sublocade injected.
4. _____ I understand that the frequency of visits will be bi-weekly initially, and will go to monthly as my treatment progresses.
5. _____ I agree to contact my specialty pharmacy directly and authorize delivery of my Sublocade at least 10 days prior to my scheduled appointment. I understand that it is my responsibility to do so and contact Park Avenue Medical, LLC to inform them that I have done so in order for my medication to be delivered on time.
6. _____ I agree to not take any other medications with Sublocade without prior permission from my provider.
7. _____ I understand that the goal of treatment for opioid dependence is to learn to live without abusing Illicit substances. Sublocade should continue as long as necessary to prevent relapse and then stop.
8. _____ I understand that I must submit a urine/oral or both for toxicology screenings upon the request of my provider. The provider may ask a clinical staff member to observe me as I provide the specimen. If my toxicology report indicates the presence of illegal/inappropriate substances or if I do not provide my own urine, it may result in discharge from the practice.
9. _____ I understand that a reaction at the site of the Sublocade injection may occur. Reactions may include pain, tenderness, indurations, swelling, redness, bruising and itching. Serious injection site reactions including tissue death.
10. _____ I understand that I may experience an allergic reaction from the Sublocade injection that includes but are not limited to; rash, hives, itching, swelling of my face, wheezing or dizziness or a decrease in consciousness.
11. _____ I understand that the most common side effects of Sublocade may include but are not limited to; decrease in blood pressure, constipation, headache, nausea, injection site itching or pain, vomiting, physical dependence and withdrawal, increased liver enzymes or liver problems and tiredness.
12. _____ I understand that I should not drink alcohol during my treatment with Sublocade.
13. _____ I understand that I should not operate any heavy machinery, or perform any other dangerous activities until I know how this medication will affect me.
14. _____ I understand that Sublocade is injected subcutaneously and should be injected every 26-30 days.

15. _____ I understand that in order for Sublocade to be ordered my provider will need to provide the specialty pharmacy personal information such as but not limited to my name, date of birth, address, phone number, insurance information and I give them permission to do so.
16. _____ I understand that if I do not contact the specialty pharmacy to authorize shipment of my Sublocade, then my next scheduled injection appointment will need to be rescheduled until the office is able to obtain my injection.
17. _____ I understand that Sublocade is a controlled substance and that the office is unable to provide samples of this medication, and that the injection must be delivered directly to the doctors office.
18. _____ I understand that I may qualify for the Sublocade Co-pay assistance program and if I do it is my responsibility to contact the specialty pharmacy to pay my co-pay in order to have my Sublocade injection delivered.
19. _____ I understand that I must inform my provider if I am pregnant, plan on becoming pregnant or breastfeeding.
20. **_____ I understand that I am strictly being treated with Sublocade for Opioid Dependence and that my treating provider is not my primary care physician, and I must continue to follow up with my PCP.**
21. _____ I consent to the above terms and agree to begin treatment with Sublocade.

Patient Signature: _____ **Date:** ____/____/____

Physician Signature: _____ **Date:** ____/____/____

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