

Naltrexone Injection Program



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Welcome to the Brigham and Women's Faulkner Hospital Naltrexone Injection Program (VITITROL)

Welcome to the Brigham and Women's Faulkner Hospital's Outpatient Naltrexone Injection Program. As a team of addiction specialists, we are excited that you are here! We want to congratulate you on your decision to participate in our program and for your commitment to change. Our commitment to you is a commitment to support you in every way we can to ensure that you are given the opportunity to succeed. Thank you for choosing our service to assist and support you in your desire to live a life in recovery and to take the necessary steps towards change.

It goes without saying that change is difficult. It is a process that happens over time. Why you want to implement change is based on your own values and your life story. How you implement change will be a combination of learning skills to manage uncomfortable feelings and situations, prevent relapse, and build a support system that will enhance your recovery.

Through newly acquired skills, you will slowly develop confidence in your process of recovery and growth. Keep in mind that change occurs slowly and at a different pace for each individual and being patient with yourself is a crucial part of this process.

You will work closely with our addiction psychiatrists who will monitor your medical needs as you move through the program. If appropriate, you will be assigned a social worker who will meet with you regularly for individual psychotherapy and counseling.

On behalf of the Brigham and Women's Faulkner Hospital Outpatient Naltrexone Program team, we applaud you for taking a positive step to change your life for the better!!



Program Faculty and Staff

Addiction Recovery Program Faculty and Staff

Fromson, John, MD
Chief of BWFH Psychiatry and Addiction Psychiatry Services

Suzuki, Joji, MD
Director, Division of Addiction Psychiatry, BWH/BWFH

Rodriguez, Claudia, MD
Director of Addiction, BWFH

El Haddad, Saria MD
Director of Addiction Recovery BWFH Day Treatment Program

Twark, Claire MD
Attending Psychiatrist

Addiction Recovery Program Counseling Staff

Julia Trumble, LICSW
Social work supervisor

Cynthia Nichols, LICSW
Licensed Social Worker

What Is Naltrexone (VIVITROL)?

Naltrexone:

- Is used for the treatment of opioid and alcohol use disorder, approved by the FDA.
- Is an opioid medication but does not activate your opioid receptors like heroin or oxycodone.
- Is NOT abusable or addictive
- Does NOT cause withdrawal if abruptly discontinued. Therefore, there is no need to taper it.
- Does NOT cause any euphoria.
- The medication comes in two formulations:
 - Injections are administered by clinic staff in our infusion clinic once monthly. This is also known as Vivitrol. Once administered, it cannot be removed and remains active in your body, blocking opioid receptors for about 28-30 days.
 - Naltrexone tablets are taken by mouth every day: For the medication to be effective by engaging your opioid receptors, at least 80% adherence is required.

For **alcohol addiction**, naltrexone blocks the pleasant feelings when you drink alcohol. This leads to:

- Reduced cravings for alcohol
- Blunted effects of alcohol when alcohol is consumed.
- Ability to remain in treatment or obtain help earlier during a relapse, reducing the potential damage that can result from a prolonged relapse.

For **opioid addiction**, naltrexone blocks opioids from taking any effect. This leads to:

- Reduced cravings for opioids
- Blocking opioids like heroin, oxycodone, fentanyl from making you “high”, without blocking your own brain’s ability to enjoy activities, like eating or exercising
- Increased risk for overdose if opioids are used after STOPPING naltrexone. Your doctor will talk to you about this risk.

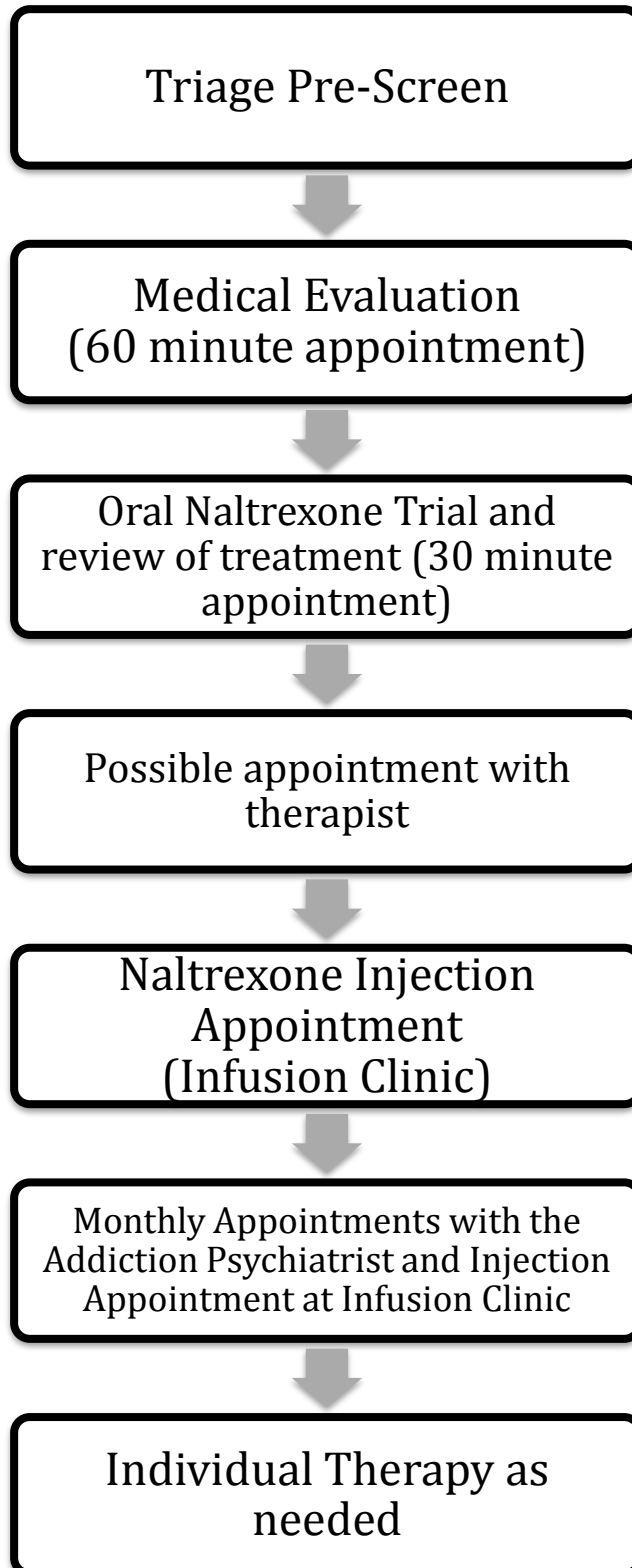
There are several benefits to receiving the injection naltrexone instead of the pills:

- A more stable dose in your body
- Improved adherence
- Lower frequency of side effects.



Naltrexone Program

Practice Overview
Alcohol Use Disorder



CONSENT TO PARTICIPATE IN EXTENDED RELEASE INJECTABLE NALTREXONE (XR-NTX, VIVITROL) TREATMENT

Patient Name: _____ **Date:** _____

I hereby authorize and give the voluntary consent to the Brigham and Women's Faulkner Hospital and its medical personnel to prescribe and administer Naltrexone Extended Release (XR-NRT) as a part of the treatment of my opioid or alcohol dependence. The treatment procedures have been explained to me in full and I understand that this will involve me allowing the administration of an intramuscular injection once every 4 weeks by nursing staff at the outpatient infusion of Brigham and Women's Faulkner Hospital, in addition to a minimum of monthly appointments with a mental health provider.

Prior to starting the injectable formulation of naltrexone, my provider will give me a minimum of one week trial of oral naltrexone to ensure that there are no side effects. In addition, I will provide urine samples for drug screening at each visit, and blood tests prior to initiating the medication to evaluate liver function and other baseline laboratory tests. Signs of liver dysfunction include yellowing of the skin, white stool or diarrhea, abdominal pain, or dark urine. If any of these signs arise during my course of treatment, I will alert my physician. If receiving the injectable formulation, there will not be any regular monitoring of liver function.

After administration of XR-NRT, an injection site reaction may occur. This can include pain, redness, tenderness, swelling, mild bruising, or itchiness. Serious injection sites should be considered if pain worsens indicating a developing infection, or if there is discharge at the site. This warrants medical attention. I understand that there is a small risk of experiencing allergic pneumonia with XR-NRT, which would include symptoms of cough, wheezing, or shortness of breath. Allergic reactions can occur after administration of XR-NRT, and unexpected symptoms such as rash, swelling of eyes or mouth, trouble breathing may arise. If any of the above occur, I should contact my provider during business hours, or visit the emergency department at any time during or after business hours.

Other common side effects of XR-NRT include nausea and dizziness. Nausea tends to subside and resolve within a few days of starting treatment. Dizziness may occur, and I understand that I should avoid driving or operating heavy machinery until I have determined how XR-NRT affects me. Allergic reactions can occur after administration of XR-NRT, and if any unexpected symptoms such as rash, swelling of eyes or mouth, trouble breathing arise, I should go to the emergency department or contact my physician.

It has been explained to me that once XR-NRT is administered, it is not possible to remove it from my body as it is an intramuscular, long acting injection. The possible side effects as well as alternative treatments have been explained to me.

OPIOIDS:

I understand that I need to be **OFF ALL OPIOIDS for a minimum of 7-10 days** prior to starting XR-NRT treatment to avoid precipitation of opioid withdrawal. If severe, this may require hospitalization.

It is my responsibility to inform my providers if I have taken any opioids prior to receiving XR-NRT. These include methadone, Suboxone, heroin, fentanyl, and/or prescription opioids, such as oxycodone, morphine, or hydrocodone.



I understand that XR-NRT is an opioid antagonist, which means that it will block effects of opioids. Using larger amount of opioids to bypass this blocking effect can lead to serious respiratory depression, overdose, and death. It has been explained to me that my tolerance for opioids will decrease significantly while on this medication so **that I may be more sensitive to lower doses of opioids and at risk of accidental overdose** should I use opioids during treatment, when my next dose is due, if I miss a dose, or after treatment is discontinued.

I understand that it is required for me to inform my medical and or psychiatric providers that I am enrolled in an opioid treatment program. I understand that it is my responsibility to update the program on any changes in my medical or insurance status. I understand that I may voluntarily withdraw from this treatment program and discontinue the use of the medications prescribed to me at any time, without re-precautions from the program. Discontinuing XR-NRT treatment will not result in symptoms of withdrawal.

I understand that it is important to carry documentation to alert medical personnel that I am on XR-NRT. I will be offered options of medical alert bracelet, wallet card, or identification tag to indicate that I am taking this medication. This identification is important in the case of an emergency, so that I receive adequate opioid treatment if pain needs to be treated. I understand that doctors may need to use other methods of pain control, such as general anesthesia, in cases of emergency.

For Female Patients of Childbearing Age: If I am, or I become pregnant while receiving treatment at the Brigham and Women's Faulkner Hospital Outpatient Naltrexone Injection Practice, I am required to inform my team of medical providers so that I may receive the appropriate care and referrals. XR-NRT is not to be continued during pregnancy, but other treatment options are available and can be discussed if pregnancy occurs. I understand that I can speak with the program physician, nurse practitioner, and/or addiction counselors about ways to optimize the healthy course of my pregnancy while I am in treatment.



NALTREXONE PROGRAM PATIENT AGREEMENT

1. ARRIVING ON TIME

- I agree to arrive to my appointments **ON TIME** and stay for the full duration of my appointment.
- I understand that if I am more than **15 minutes late** to my appointment that I will need to reschedule.
- I understand that *if I am late or miss my appointment, I will not receive my monthly injection.*

*Exceptions are made on a case to case basis with a valid reason.

- I understand that the administration of the injection is dependent on my adherence to program expectations, including maintain my appointments with my physician, therapist, and participating in weekly group (for individuals with opioid use disorder)

2. ADMINISTRATION OF XR-NTX INJECTION

- I understand that my appointments will take place on Wednesday afternoons between 1:30-3:30. If I miss my appointment, I will have to wait 1-2 weeks to receive my injection.
- I must contact the outpatient infusion clinic at **617-983-7521, option 2**, at least **45 minutes** ahead of my scheduled appointment time and leave a message informing staff that I will be coming in.
- I understand that **two consecutive missed or no-show appointments** (includes appointments cancelled within 24 hours of scheduled appointment) will result in an action plan and may involve referral to higher level of care (e.g. Evening treatment program, increased individual therapy, partial program).
- I understand that **three consecutive missed or no-show appointments** (includes appointments cancelled within 24 hours of scheduled appointment) will result in loss of the ability to receive injectable XR-NTX. This may require referral to a different program or consideration of another medication for alcohol or opioid use disorder.
- I understand that walk-in appointments are **NOT acceptable**.

3. PRIOR TO RECEIVING VIVITROL INJECTION

- I understand that if I have used opioids within the last 7-10 days, I will be at a significant risk of going into withdrawal following administration of the injection. **It is my responsibility to inform my provider of a recent lapse.** I am aware that sharing information about a lapse will **NOT** result in discharge from the program, and instead allow me to work with my provider to continue my path of recovery. I can **cancel my injection appointment** with the OPIC by calling **617-983-7521, option 3**.
- I understand that if I am prescribed opioids for acute pain, I will need to inform my provider of this as soon as possible.
- I understand that it is important to communicate to my care team the start of any new medication.
- I understand that I need to inform my treatment team of any upcoming surgical, dental, or medical procedures that may require opioid analgesia. If relevant, my XR-NRT will be held and other treatment options can take place acutely until completion of opioid treatment.



4. MISSED AND NO-SHOW APPOINTMENTS

- I understand that **two consecutive missed or no-show appointments** will result in an action plan and may involve referral to higher level of care (e.g. Evening treatment program, increased individual therapy, dual diagnosis day treatment program).
- I understand that **three consecutive missed or no-show appointments** without a valid excuse will result in discharge from the program.
- I understand that walk-in appointments are **NOT acceptable**.

5. NOTIFICATION OF ABSENCE

- I agree to give at least a **24-hour** notice before the start of the treatment day if I am unable to attend appointments with my physician or therapist. Please call **(617) 983-7474, option 1**, and leave a message. You can also contact your provider through patient gateway.
- Please make all attempts to reschedule your missed appointment with the front desk staff. If you need medications prior to rescheduled appointment, please notify staff or include in your message your **NAME, MEDICATION NAME AND DOSE NEEDED, AND PHARMACY**
- For my XR-NTX injection appointments, I must give over 24 hours' notice or will be considered "no show". I can **cancel my injection appointment** with the OPIC by calling **617-983-7521, option 3**.
- For an appointment to be considered "cancelled" with the infusion clinic, I must call over 24 hours ahead of time if I cannot make it to my injection appointment or cannot receive the injection (e.g. Unexpected lapse in opioid use, prescription for opioid, upcoming procedure requiring an opioid). **Any cancellation within 24 hours of the appointment will be considered a no show.**
- If I am sick, I understand that it is ok for me to call and inform the staff that I will not be able to come in for my appointment. We care about your health, and that of others, and when sick, prefer that you stay home to take care of yourself and avoid potentially getting others sick.

6. DRUG SCREENS

- **I understand that urine drug screens are a mandatory program requirement.**
- I agree to provide a urine drug-screen at each visit if required by my provider while engaged in the program.
- I understand that **tampering with my urine** is grounds for **immediate discharge**.
- I understand that **a missed drug screen** will be considered a **positive result**.
- I understand that **3 missed drug screens** will result in a discharge from the program.
- I understand that this is substance use disorder program therefore; consecutive positive drug screens will result in a ***30-day Action Plan*** (weekly) ***60-day Action Plan*** (monthly) intended to give me more support in my recovery.
- I understand that if I continue to struggle with my substance use while on an action plan this will result in an individual treatment team meeting with the clinical team to determine my eligibility to remain in the program.

I understand that the clinical team may recommend admission for medically supervised withdrawal or a referral to a higher level of care.

7. PRESCRIBED MEDICATIONS

- Your prescriber is **REQUIRED** to review the prescription monitoring program, a statewide database that reflects any recent controlled substances prescribed.



- I understand that if I am prescribed opioids for acute pain, I will need to inform my provider of this as soon as possible as opioid medications may interact with prescribed medications.
- I understand that it is important to communicate to my care team the start of any new medication.
- I understand that I need to inform my treatment team of any upcoming surgical, dental, or medical procedures that may require opioid analgesia. If relevant, my XR-NRT will be held and other treatment options can take place acutely until completion of opioid treatment. This will make your treatment **easier**.

8. TELEPHONE CALLS

- I understand that phone calls and voice mails will be returned within **24-48 hours (1-2 business days, does not include weekends)**. It is best to call one time and leave a **detailed** message with front desk staff indicating what is needed. Please be aware that if not urgent, your provider may not be able to call you back for two days. You do not need to call multiple times, as messages will be taken care of in the order they are received.
- Messages and phone calls after 4:30 PM may not be heard until the following morning. If emergencies arise, please contact 911 or visit your nearest emergency room.
- I understand that if the program calls me, I have a responsibility to return the call. Not doing so may result in increased urine toxicology screens, return to higher level of frequency of treatment, etc. based on the purpose of the call.
- For an alternative mode of communication, consider signing up for patient gateway.
<https://patientgateway.partners.org>

9. PRESCRIPTION REFILLS

- I understand that it may take up to three business days to respond to a prescription refill made outside of a scheduled (or cancelled) appointment.
- Call 617-983-7474 (option 3) and leave a detailed message on the prescription refill request line.
- Use patient gateway to request your prescription refill.
- If you leave a voice message or speak to front desk staff, please include medication name, dose, and pharmacy to which to send the prescription.
- I agree to fill my medications by 4:00 PM on Fridays. If my prescription is filled later, or on the weekend, and issues arise, it will be more difficult for my provider to help in a timely manner. Weekend staff may not be able to help. It is my responsibility to ensure that my prescriptions are filled prior to the weekend.

10. PRIOR AUTHORIZATIONS

- It is my responsibility to contact the clinic at **617-983-7474 option 1** if my prescription requires a prior authorization.
- I understand that prior authorizations may take up to **48-72 hours** to get approved by my insurance company once it is submitted. My prescriber does not have any control over how quickly these get approved

9. LETTERS OR FORMS

- I understand that if I need a letter printed or a form filled out I need to allow sufficient time for my provider to complete the information necessary. It may take up to **5 business days** for my provider to provide documentation needed.



- Exception: Same day letters that indicate your presence in the clinic can be provided the day of your appointment.

11. RANDOM PILL COUNTS AND URINE DRUG SCREENS

- I agree to random pill counts (if on a controlled substance) and drug screens by the clinical team as this is part of the program policy. I understand that if called for random urine drug screen, I will have 48 hours to provide a screen.

12. CONFIDENTIALITY

- I agree to respect the confidentiality of all the members in the program.
- I understand that my confidentiality is a priority of the Addiction Recovery Program.

13. SEXUALIZING BEHAVIOR/ACTIVITY

- I agree that any form of sexualizing behavior and/or sexual activity occurring at the program will result in immediate administrative discharge.

14. GAMBLING

- I agree that gambling in any form is not permitted on hospital grounds.

15. LANGUAGE

- I agree that offensive language or remarks that demean or degrade others are prohibited.

16. WEAPONS

- I agree to not carry weapons on hospital grounds. This includes tools that may be considered weapons, including knives, hammers, etc.

17. CELL PHONES

- I understand that the use of cell phones during group and individual appointments is not permitted.

18. MANDATED REPORTERS

- My physician and social workers are mandated reporters in the state of Massachusetts. Under Massachusetts State Law this program is required to report reasonable suspicions of abuse or neglect to state agencies for all children, elderly, and disabled persons.
- The standard for reporting suspected abuse or neglect in Massachusetts is any situation where there is a reasonable suspicion to believe that abuse or neglect exists. Neglect may include patient on patient abuse.

19. ACTION PLAN STATUS

- Action Plans are a clinical treatment intervention intended to give you more support in your recovery.
- Grounds for an Action Plan include any of the following:
 - Disrespectful behavior/language with any of the treatment staff, including front desk staff.



- Possession and/or use of ANY alcohol or drugs except those appropriately prescribed to me by my outpatient medical/psychiatric team.
- An attempt to sell and/or distribute ANY alcohol or drugs including prescribed medication on or off hospital grounds. This may result in discharge.
- Continued positive urine toxicology screens and or urine samples not reflecting treatment protocol.
- Action Plans can include any or all of the following treatment interventions determined by the clinical team:
 - Increased frequency of drug screens.
 - Individual counseling sessions for more support in my recovery.
 - Attendance to intensive outpatient or dual partial program level of care.
 - Admission to unit for medically supervised withdrawal/detoxification unit.
- Failure to adhere to the Action Plan guidelines will result in discharge from the practice.

20. ADMINISTRATIVE DISCHARGE

- I understand that if I am administratively discharged from the practice I will not be considered eligible for readmission for a 3-month period.
- Reasons for administrative discharge include:
 - Tampering with urine toxicology
 - Sexualizing behavior/sexual activity at the program
 - Threatening or assaultive behaviors towards other patients or program staff
 - Selling of illicit drugs on hospital grounds
 - Any criminal activity against program or staff, including stealing

Threats of violence, abusive behavior or destruction of property will result in a one-year ban from elective admission. Violence or providing alcohol or drugs will result in a permanent ban from elective admission to any of the Addiction Recovery Program treatment modalities. I understand these expectations and agree to abide by the rules of the program.

You will sign this with your provider at your initial visit. Please keep this copy for your reference.



Additional Resources at BWFH

Other Groups through ARP

Seeking Safety

PTSD and comorbid substance use disorder

Men: Thursdays @ 11:30-12:15 AM / Women: Fridays @ 9:30-10:15 AM

Relapse Prevention

Wednesdays 3:00-3:45 PM

Mom's Group

Pregnancy and new moms

Tuesdays 2:00-2:45 PM

Self-Help Meetings

SMART Recovery

Tuesdays @ 7:00 pm - 9:00 pm

Huvos Auditorium 3rd Floor

Grad Group AWOL (Invitation only)

Wednesdays Group

Group Room 2 & 3: 2nd Floor Outpatient Psychiatry Department

Alcoholics Anonymous (Beginners)

Fridays @ 7:00 pm - 8:00 pm

Huvos Auditorium 3rd Floor

Alcoholics Anonymous

Fridays @ 8:00 pm - 9:30 pm

Huvos Auditorium 3rd Floor

Al-Anon

Fridays @ 8:00 pm - 9:30 pm

Group Room 3: 2nd Floor Outpatient Psychiatry Department

Addiction Recovery Graduate Group

(Brigham and Women's Faulkner Hospital Program Graduates and Current Patients Only)

Sundays @ 10:00 am - 12:00pm

Huvos Auditorium 3rd Floor

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Patient Name: _____ **Date:** _____

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Prior to starting the injectable formulation of naltrexone, my provider will give me a minimum of one week trial of oral naltrexone to ensure that there are no side effects. In addition, I will provide urine samples for drug screening at each visit, and blood tests prior to initiating the medication to evaluate liver function and other baseline laboratory tests. Signs of liver dysfunction include yellowing of the skin, white stool or diarrhea, abdominal pain, or dark urine. If any of these signs arise during my course of treatment, I will alert my physician. If receiving the injectable formulation, there will not be any regular monitoring of liver function.

After administration of XR-NRT, an injection site reaction may occur. This can include pain, redness, tenderness, swelling, mild bruising, or itchiness. Serious injection sites should be considered if pain worsens indicating a developing infection, or if there is discharge at the site. This warrants medical attention. I understand that there is a small risk of experiencing allergic pneumonia with XR-NRT, which would include symptoms of cough, wheezing, or shortness of breath. Allergic reactions can occur after administration of XR-NRT, and unexpected symptoms such as rash, swelling of eyes or mouth, trouble breathing may arise. If any of the above occur, I should contact my provider during business hours, or visit the emergency department at any time during or after business hours.

Other common side effects of XR-NRT include nausea and dizziness. Nausea tends to subside and resolve within a few days of starting treatment. Dizziness may occur, and I understand that I should avoid driving or operating heavy machinery until I have determined how XR-NRT affects me. Allergic reactions can occur after administration of XR-NRT, and if any unexpected symptoms such as rash, swelling of eyes or mouth, trouble breathing arise, I should go to the emergency department or contact my physician.

It has been explained to me that once XR-NRT is administered, it is not possible to remove it from my body as it is an intramuscular, long acting injection. The possible side effects as well as alternative treatments have been explained to me.

OPIOIDS:

I understand that I need to be **OFF ALL OPIOIDS for a minimum of 7-10 days** prior to starting XR-NRT treatment to avoid precipitation of opioid withdrawal. If severe, this may require hospitalization.

It is my responsibility to inform my providers if I have taken any opioids prior to receiving XR-NRT. These include methadone, Suboxone, heroin, fentanyl, and/or prescription opioids, such as oxycodone, morphine, or hydrocodone.

I understand that XR-NRT is an opioid antagonist, which means that it will block effects of opioids. Using larger amount of opioids to bypass this blocking effect can lead to serious respiratory depression, overdose, and death. It has been explained to me that my tolerance for opioids will decrease significantly while on this medication so **that I may be more sensitive to lower doses of opioids and at risk of accidental overdose** should I use opioids during treatment, when my next dose is due, if I miss a dose, or after treatment is discontinued.

I understand that it is required for me to inform my medical and or psychiatric providers that I am enrolled in an opioid treatment program. I understand that it is my responsibility to update the program on any changes in my medical or insurance status. I understand that I may voluntarily withdraw from this treatment program and discontinue the use of the medications prescribed to me at any time, without re-precautions from the program. Discontinuing XR-NRT treatment will not result in symptoms of withdrawal.

I understand that it is important to carry documentation to alert medical personnel that I am on XR-NRT. I will be offered options of medical alert bracelet, wallet card, or identification tag to indicate that I am taking this medication. This identification is important in the case of an emergency, so that I receive adequate opioid treatment if pain needs to be treated. I understand that doctors may need to use other methods of pain control, such as general anesthesia, in cases of emergency.

For Female Patients of Childbearing Age: If I am, or I become pregnant while receiving treatment at the Brigham and Women's Faulkner Hospital Outpatient Naltrexone Injection Practice, I am required to inform my team of medical providers so that I may receive the appropriate care and referrals. XR-NRT is not to be continued during pregnancy, but other treatment options are available and can be discussed if pregnancy occurs. I understand that I can speak with the program physician, nurse practitioner, and/or addiction counselors about ways to optimize the healthy course of my pregnancy while I am in treatment.

Patient Signature: _____ **Date:** _____ **Time:** _____

Physician/Nurse Practitioner: _____ **Date:** _____ **Time:** _____



NALTREXONE PROGRAM PATIENT AGREEMENT

1. ARRIVING ON TIME

Initials: _____

- I agree to arrive to my appointments **ON TIME** and stay for the full duration of my appointment.
- I understand that if I am more than **15 minutes late** to my appointment that I will need to reschedule.
- I understand that *if I am late or miss my appointment, I will not receive my monthly injection.*

*Exceptions are made on a case to case basis with a valid reason.

- I understand that the administration of the injection is dependent on my adherence to program expectations, including maintain my appointments with my physician, therapist, and participating in weekly group (for individuals with opioid use disorder)

2. ADMINISTRATION OF XR-NTX INJECTION

Initials: _____

- I understand that my appointments will take place on Wednesday afternoons between 1:30-3:30. If I miss my appointment, I will have to wait 1-2 weeks to receive my injection.
- I must contact the outpatient infusion clinic at **617-983-7521, option 2**, at least **45 minutes** ahead of my scheduled appointment time and leave a message informing staff that I will be coming in.
- I understand that **two consecutive missed or no-show appointments** (includes appointments cancelled within 24 hours of scheduled appointment) will result in an action plan and may involve referral to higher level of care (e.g. Evening treatment program, increased individual therapy, partial program).
- I understand that **three consecutive missed or no-show appointments** (includes appointments cancelled within 24 hours of scheduled appointment) will result in loss of the ability to receive injectable XR-NTX. This may require referral to a different program or consideration of another medication for alcohol or opioid use disorder.
- I understand that walk-in appointments are **NOT acceptable**.

3. PRIOR TO RECEIVING VIVITROL INJECTION

Initials: _____

- I understand that if I have used opioids within the last 7-10 days, I will be at a significant risk of going into withdrawal following administration of the injection. **It is my responsibility to inform my provider of a recent lapse.** I am aware that sharing information about a lapse will **NOT** result in discharge from the program, and instead allow me to work with my provider to continue my path of recovery. I can **cancel my injection appointment** with the OPIC by calling **617-983-7521, option 3**.
- I understand that if I am prescribed opioids for acute pain, I will need to inform my provider of this as soon as possible.
- I understand that it is important to communicate to my care team the start of any new medication.
- I understand that I need to inform my treatment team of any upcoming surgical, dental, or medical procedures that may require opioid analgesia. If relevant, my XR-NRT will be held and other treatment options can take place acutely until completion of opioid treatment.



4. MISSED AND NO-SHOW APPOINTMENTS

Initials: _____

- I understand that **two consecutive missed or no-show appointments** will result in an action plan and may involve referral to higher level of care (e.g. Evening treatment program, increased individual therapy, dual diagnosis day treatment program).
- I understand that **three consecutive missed or no-show appointments** without a valid excuse will result in discharge from the program.
- I understand that walk-in appointments are **NOT acceptable**.
- If I am sick, I understand that it is ok for me to call and inform the staff that I will not be able to come in for my appointment. We care about your health, and that of others, and when sick, prefer that you stay home to take care of yourself and avoid potentially getting others sick.

5. NOTIFICATION OF ABSENCE

Initials: _____

- I agree to give at least a **24-hour** notice before the start of the treatment day if I am unable to attend appointments with my physician or therapist. Please call **(617) 983-7474, option 1**, and leave a message. You can also contact your provider through patient gateway.
- Please make all attempts to reschedule your missed appointment with the front desk staff. If you need medications prior to rescheduled appointment, please notify staff or include in your message your **NAME, MEDICATION NAME AND DOSE NEEDED, AND PHARMACY**.
- For my XR-NTX injection appointments, I must give over 24 hours' notice or will be considered "no show". I can **cancel my injection appointment** with the OPIC by calling **617-983-7521, option 3**.
- For an appointment to be considered "cancelled" with the infusion clinic, I must call over 24 hours ahead of time if I cannot make it to my injection appointment or cannot receive the injection (e.g. Unexpected lapse in opioid use, prescription for opioid, upcoming procedure requiring an opioid). **Any cancellation within 24 hours of the appointment will be considered a no show.**
- If I am sick, I understand that it is ok for me to call and inform the staff that I will not be able to come in for my appointment. We care about your health, and that of others, and when sick, prefer that you stay home to take care of yourself and avoid potentially getting others sick.

6. DRUG SCREENS

Initials: _____

- **I understand that urine drug screens are a mandatory program requirement.**
- I agree to provide a urine drug-screen at each visit if required by my provider while engaged in the program. **Random screens are required if I am being prescribed ANY controlled substance.**
- I understand that **tampering with my urine** is grounds for **immediate discharge**.
- I understand that **a missed drug screen** will be considered a **positive result**.
- I understand that **3 missed drug screens** will result in a discharge from the program.
- I understand that this is substance use disorder program therefore; consecutive positive drug screens will result in a **30-day Action Plan** (weekly) **60-day Action Plan** (monthly) intended to give me more support in my recovery.
- I understand that if I continue to struggle with my substance use while on an action plan this will result in an individual treatment team meeting with the clinical team to determine my eligibility to remain in the program.

I understand that the clinical team may recommend admission for medically supervised withdrawal or a referral to a higher level of care



7. PRESCRIBED MEDICATIONS

Initials: _____

- Your prescriber is **REQUIRED** to review the prescription monitoring program, a statewide database that reflects any recent controlled substances prescribed.
- I understand that if I am prescribed opioids for acute pain, I will need to inform my provider of this as soon as possible as opioid medications may interact with prescribed medications.
- I understand that it is important to communicate to my care team the start of any new medication.
- I understand that I need to inform my treatment team of any upcoming surgical, dental, or medical procedures that may require opioid analgesia. If relevant, my XR-NRT will be held and other treatment options can take place acutely until completion of opioid treatment. This will make your treatment **easier**.

8. TELEPHONE CALLS

Initials: _____

- I understand that phone calls and voice mails will be returned within **24-48 hours (1-2 business days, does not include weekends)**. It is best to call one time and leave a **detailed** message with front desk staff indicating what is needed. Please be aware that if not urgent, your provider may not be able to call you back for two days. You do not need to call multiple times, as messages will be taken care of in the order they are received.
- Messages and phone calls after 4:30 PM may not be heard until the following morning. If emergencies arise, please contact 911 or visit your nearest emergency room.
- I understand that if the program calls me, I have a responsibility to return the call. Not doing so may result in increased urine toxicology screens, return to higher level of frequency of treatment, etc. based on the purpose of the call.
- For an alternative mode of communication, consider signing up for patient gateway.
<https://patientgateway.partners.org>

9. PRESCRIPTION REFILLS

Initials: _____

- I understand that it may take up to three business days to respond to a prescription refill made outside of a scheduled (or cancelled) appointment.
- Call 617-983-7474 (option 3) and leave a detailed message on the prescription refill request line.
- Use patient gateway to request your prescription refill.
- If you leave a voice message or speak to front desk staff, please include medication name, dose, and pharmacy to which to send the prescription.
- I agree to fill my medications by 4:00 PM on Fridays. If my prescription is filled later, or on the weekend, and issues arise, it will be more difficult for my provider to help in a timely manner. Weekend staff may not be able to help. It is my responsibility to ensure that my prescriptions are filled prior to the weekend.

10. PRIOR AUTHORIZATIONS

Initials: _____

- It is my responsibility to contact the clinic at **617-983-7474 option 1** if my prescription requires a prior authorization.
- I understand that prior authorizations may take up to **48-72 hours** to get approved by my insurance company once it is submitted. My prescriber does not have any control over how quickly these get approved



11. LETTERS OR FORMS

Initials: _____

- I understand that if I need a letter printed or a form filled out I need to allow sufficient time for my provider to complete the information necessary. It may take up to **5 business days** for my provider to provide documentation needed.
- Exception: Same day letters that indicate your presence in the clinic can be provided the day of your appointment.

12. RANDOM PILL COUNTS AND URINE DRUG SCREENS

Initials: _____

- I agree to random pill counts (if on a controlled substance) and drug screens by the clinical team as this is part of the program policy. I understand that if called for random urine drug screen, I will have 48 hours to provide a screen.

13. CONFIDENTIALITY

Initials: _____

- I agree to respect the confidentiality of all the members in the program.
- I understand that my confidentiality is a priority of the Addiction Recovery Program.

14. SEXUALIZING BEHAVIOR/ACTIVITY

Initials: _____

- I agree that any form of sexualizing behavior and/or sexual activity occurring at the program will result in immediate administrative discharge.

15. GAMBLING

Initials: _____

- I agree that gambling in any form is not permitted on hospital grounds.

16. LANGUAGE

Initials: _____

- I agree that offensive language or remarks that demean or degrade others are prohibited.

17. WEAPONS

Initials: _____

- I agree to not carry weapons on hospital grounds. This includes tools that may be considered weapons, including knives, hammers, etc.

18. CELL PHONES

Initials: _____

- I understand that the use of cell phones during group and individual appointments is not permitted.

19. MANDATED REPORTERS

Initials: _____

- My physician and social workers are mandated reporters in the state of Massachusetts. Under Massachusetts State Law this program is required to report reasonable suspicions of abuse or neglect to state agencies for all children, elderly, and disabled persons.
- The standard for reporting suspected abuse or neglect in Massachusetts is any situation where there is a reasonable suspicion to believe that abuse or neglect exists. Neglect may include patient on patient abuse.

20. ACTION PLAN STATUS

Initials: _____

- Action Plans are a clinical treatment intervention intended to give you more support in your recovery.
- Grounds for an Action Plan include any of the following:



- Disrespectful behavior/language with any of the treatment staff, including front desk staff.
- Possession and/or use of ANY alcohol or drugs except those appropriately prescribed to me by my outpatient medical/psychiatric team.
- An attempt to sell and/or distribute ANY alcohol or drugs including prescribed medication on or off hospital grounds. This may result in discharge.
- Continued positive urine toxicology screens and or urine samples not reflecting treatment protocol.
- Action Plans can include any or all of the following treatment interventions determined by the clinical team:
 - Increased frequency of drug screens.
 - Individual counseling sessions for more support in my recovery.
 - Attendance to intensive outpatient or dual partial program level of care.
 - Admission to unit for medically supervised withdrawal/detoxification unit.
- Failure to adhere to the Action Plan guidelines will result in discharge from the practice.

21. ADMINISTRATIVE DISCHARGE

Initials: _____

- I understand that if I am administratively discharged from the practice I will not be considered eligible for readmission for a 3-month period.
- Reasons for administrative discharge include:
 - Tampering with urine toxicology
 - Sexualizing behavior/sexual activity at the program
 - Threatening or assaultive behaviors towards other patients or program staff
 - Selling of illicit drugs on hospital grounds
 - Any criminal activity against hospital or staff, including stealing.

Threats of violence, abusive behavior or destruction of property will result in a one-year ban from elective admission. Violence or providing alcohol or drugs will result in a permanent ban from elective admission to any of the Addiction Recovery Program treatment modalities. I understand these expectations and agree to abide by the rules of the program.

Patient Signature: _____ **Date:** _____ **Time:** _____

Clinician/MD Signature: _____ **Date:** _____ **Time:** _____