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STATE OF IOWA

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IOWA BOARD OF MEDICINE  
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## Board encourages physicians to treat patients' pain responsibly

DES MOINES, IA – The Iowa Board of Medicine has re-issued its 2009 policy statement on pain management to reinforce that Iowa physicians who responsibly diagnose and treat patients' pain should not be at risk of disciplinary action.

The statement (below), which is also endorsed by the Iowa Boards of Nursing, Pharmacy and Physician Assistants, declares that patients “deserve to have their pain well managed, whether it's acute or chronic, mild or severe.”

Recent publicity regarding Iowa physicians facing criminal charges or medical board actions for overprescribing controlled substances, particularly opioids for pain, may be causing a dampening effect on patients' access to legitimate and necessary pain control services and medicines.

Chairman Hamed Tewfik, M.D, said the Board is aware of these issues and wishes to assure Iowa physicians if they have a reasonable and responsible approach to such treatment they are unlikely to come under Board scrutiny.

A reasonable and responsible approach outlined in the Board's administrative rules (below) includes performing adequate patient assessments, thorough documentation, ongoing patient monitoring of drug use, use of pain management agreements (below), regularly reviewing patient data in the Iowa Prescription Monitoring Database, and timely use of consults, for example mental health professionals, neurologists, pain management experts and physical therapists.

The Board is also encouraging Iowa physicians to complete mandatory continuing medical education activities on pain management by the August 17, 2016, deadline.

**A Joint Statement on Pain by the Iowa Boards of  
Medicine, Nursing, Pharmacy and Physician Assistants**

**Adopted by the Iowa Boards of Medicine 8/28/08, Nursing 12/6/07,  
Pharmacy 10/7/08 and Physician Assistants 1/21/09**

**The Iowa Boards of Medicine, Nursing, Pharmacy and Physician Assistants join  
together in a commitment to improve the pain management services for all Iowa  
residents.**

Health care practitioners, i.e., medical doctors, osteopathic physicians, advanced practice nurses, registered nurses, licensed practical nurses, pharmacists and physician assistants care for patients regularly who have pain. Patients deserve to have their pain well managed, whether it's acute or chronic, mild or severe. Health care practitioners should, within their legal scope of practice, attend to patients' pain.

The goal of pain management is to treat each patient's pain in relation to the patient's overall health, including physical function and psychological, social and work-related factors. Although pain management is not an exact science, the Boards recognize that much can be done to treat pain more appropriately. Unmanaged or inappropriately treated pain impacts patients' quality of life, reduces patients' ability to be productive members of society and increases patients' use of health care services.

To effectively assist patients in managing their pain, health care practitioners should, within their legal scope of practice:

- 1.** Routinely assess all patients for pain. All pain should be evaluated with an appropriate history and physical and with laboratory and diagnostic testing, if indicated.
- 2.** Draw on the expertise that other health care practitioners offer in treating patients' pain and work cooperatively with them to balance between pain relief and sedation, keeping in mind each patient's level of pain, overall health and need to attend to family and other responsibilities. Utilize non-pharmacological and pharmacological approaches to the treatment of pain and suffering.
- 3.** Regularly evaluate the effectiveness of the treatment plan and work together to alter the plan or seek consultation/referrals if the treatment is not providing optimal pain relief.
- 4.** Document the assessment, plan of care and response to care in a clear, consistent, thorough and accurate manner. Patients should be informed of the risks and benefits when controlled substances or highly abusable drugs are prescribed in the ambulatory care setting. Documentation should be sufficiently detailed so that other practitioners can understand the original practitioner's findings and thought processes.

- 5.** Anticipate and effectively manage side effects of pain medication, e.g., nausea, constipation, fatigue, depression and anxiety.
- 6.** Become knowledgeable about effective pain management.
- 7.** Learn about addiction. Patients with addictions deserve to have their pain treated effectively. Patients in recovery from addiction who have pain should have their pain treated effectively while minimizing the recurrence of their addiction.
- 8.** Minimize the risk of diversion of drugs by using a pain management contract for chronic pain patients prescribed controlled substances and other abusable drugs.<sup>1</sup> A licensed health care practitioner involved in the care of a patient in pain should not be at risk of disciplinary action from their respective licensing board for prescribing, dispensing or administering controlled substances, including opioid analgesics, for a legitimate medical purpose, based on accepted scientific knowledge, sound clinical judgment and adequate documentation.



## PAIN TREATMENT-RELATED ADMINISTRATIVE RULES FOR IOWA-LICENSED PHYSICIANS

MAY 2014

- **653-13.2 – Appropriate Pain Management**
- **653-13.9 – Interventional Chronic Pain Management**
- **652-11.4 – CME requirements on pain management and palliative care**

### IOWA ADMINISTRATIVE CODE 653—13.2

Standards of practice—appropriate pain management. This rule establishes standards of practice for the management of acute and chronic pain. The board encourages the use of adjunct therapies such as acupuncture, physical therapy and massage in the treatment of acute and chronic pain. This rule focuses on prescribing and administering controlled substances to provide relief and eliminate suffering for patients with acute or chronic pain.

1. This rule is intended to encourage appropriate pain management, including the use of controlled substances for the treatment of pain, while stressing the need to establish safeguards to minimize the potential for substance abuse and drug diversion.
2. The goal of pain management is to treat each patient's pain in relation to the patient's overall health, including physical function and psychological, social and work-related factors. At the end of life, the goals may shift to palliative care.
3. The board recognizes that pain management, including the use of controlled substances, is an important part of general medical practice. Unmanaged or inappropriately treated pain impacts patients' quality of life, reduces patients' ability to be productive members of society, and increases patients' use of health care services.
4. Physicians should not fear board action for treating pain with controlled substances as long as the physicians' prescribing is consistent with appropriate pain management practices. Dosage alone is not the sole measure of determining whether a physician has complied with appropriate pain management practices. The board recognizes the complexity of treating patients with chronic pain or a substance abuse history. Generally, the board is concerned about a pattern of improper pain management or a single occurrence of willful or gross overtreatment or undertreatment of pain.
5. The board recognizes that the undertreatment of pain is a serious public health problem that results in decreases in patients' functional status and quality of life, and that adequate access by patients to proper pain treatment is an important objective of any pain management policy.
6. Inappropriate pain management may include nontreatment, undertreatment, overtreatment, and the continued use of ineffective treatments. Inappropriate pain

management is a departure from the acceptable standard of practice in Iowa and may be grounds for disciplinary action.

**13.2(1) Definitions. For the purposes of this rule, the following terms are defined as follows:**

"Acute pain" means the normal, predicted physiological response to a noxious chemical, thermal or mechanical stimulus and typically is associated with invasive procedures, trauma and disease. Generally, acute pain is self-limited, lasting no more than a few weeks following the initial stimulus.

"Addiction" means a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include the following: impaired control over drug use, craving, compulsive use, and continued use despite harm. Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and are not the same as addiction.

"Chronic pain" means persistent or episodic pain of a duration or intensity that adversely affects the functioning or well-being of a patient when (1) no relief or cure for the cause of pain is possible; (2) no relief or cure for the cause of pain has been found; or (3) relief or cure for the cause of pain through other medical procedures would adversely affect the well-being of the patient. If pain persists beyond the anticipated healing period of a few weeks, patients should be thoroughly evaluated for the presence of chronic pain.

"Pain" means an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage. Pain is an individual, multifactorial experience influenced by culture, previous pain events, beliefs, mood and ability to cope.

"Physical dependence" means a state of adaptation that is manifested by drug class-specific signs and symptoms that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, or administration of an antagonist. Physical dependence, by itself, does not equate with addiction.

"Pseudoaddiction" means an iatrogenic syndrome resulting from the misinterpretation of relief-seeking behaviors as though they are drug-seeking behaviors that are commonly seen with addiction. The relief-seeking behaviors resolve upon institution of effective analgesic therapy.

"Substance abuse" means the use of a drug, including alcohol, by the patient in an inappropriate manner that may cause harm to the patient or others, or the use of a drug for an indication other than that intended by the prescribing clinician. An abuser may or may not be physically dependent on or addicted to the drug.

"Tolerance" means a physiological state resulting from regular use of a drug in which an increased dosage is needed to produce a specific effect, or a reduced effect is observed with a constant dose over time. Tolerance may or may not be evident during opioid treatment and does not equate with addiction.

"Undertreatment of pain" means the failure to properly assess, treat and manage pain or the failure to appropriately document a sound rationale for not treating pain.

**13.2(2) Laws and regulations governing controlled substances.**

Nothing in this rule relieves a physician from fully complying with applicable federal and state laws and regulations governing controlled substances.

### **13.2(3) Undertreatment of pain.**

The undertreatment of pain is a departure from the acceptable standard of practice in Iowa. Undertreatment may include a failure to recognize symptoms and signs of pain, a failure to treat pain within a reasonable amount of time, a failure to allow interventions, e.g., analgesia, to become effective before invasive steps are taken, a failure to address pain needs in patients with reduced cognitive status, a failure to use controlled substances for terminal pain due to the physician's concern with addicting the patient, or a failure to use an adequate level of pain management.

### **13.2(4) Assessment and treatment of acute pain.**

Appropriate assessment of the etiology of the pain is essential to the appropriate treatment of acute pain. Acute pain is not a diagnosis; it is a symptom. Prescribing controlled substances for the treatment of acute pain should be based on clearly diagnosed and documented pain. Appropriate management of acute pain should include an assessment of the mechanism, type and intensity of pain. The patient's medical record should clearly document a medical history, a pain history, a clinical examination, a medical diagnosis and a treatment plan.

### **13.2(5) Effective management of chronic pain.**

Prescribing controlled substances for the treatment of chronic pain should only be accomplished within an established physician-patient relationship and should be based on clearly diagnosed and documented unrelieved pain. To ensure that chronic pain is properly assessed and treated, a physician who prescribes or administers controlled substances to a patient for the treatment of chronic pain shall exercise sound clinical judgment and establish an effective pain management plan in accordance with the following:

#### **a. Patient evaluation.**

A patient evaluation that includes a physical examination and a comprehensive medical history shall be conducted prior to the initiation of treatment. The evaluation shall also include an assessment of the pain, physical and psychological function, diagnostic studies, previous interventions, including medication history, substance abuse history and any underlying or coexisting conditions. Consultation/referral to a physician with expertise in pain medicine, addiction medicine or substance abuse counseling or a physician who specializes in the treatment of the area, system, or organ perceived to be the source of the pain may be warranted depending upon the expertise of the physician and the complexity of the presenting patient. Interdisciplinary evaluation is strongly encouraged.

#### **b. Treatment plan.**

The physician shall establish a comprehensive treatment plan that tailors drug therapy to the individual needs of the patient. To ensure proper evaluation of the success of the treatment, the plan shall clearly state the objectives of the treatment, for example, pain relief or improved physical or psychosocial functioning. The treatment plan shall also indicate if any further diagnostic evaluations or treatments are planned and their purposes. The treatment plan shall also identify any other treatment modalities and rehabilitation programs utilized. The patient's short- and long-term needs for pain relief shall be considered when drug therapy is prescribed. The patient's ability to request pain relief as well as the patient setting shall be considered. For example, nursing home patients are unlikely to have their pain control needs assessed on a regular basis, making prn (on an as-needed basis) drugs less effective than drug therapy prescribed for routine administration that can be supplemented if pain is found to be worse. The patient should receive prescriptions for controlled substances from a single physician and a single pharmacy whenever possible.

c. Informed consent.

The physician shall document discussion of the risks and benefits of controlled substances with the patient or person representing the patient.

d. Periodic review.

The physician shall periodically review the course of drug treatment of the patient and the etiology of the pain. The physician should adjust drug therapy to the individual needs of each patient. Modification or continuation of drug therapy by the physician shall be dependent upon evaluation of the patient's progress toward the objectives established in the treatment plan. The physician shall consider the appropriateness of continuing drug therapy and the use of other treatment modalities if periodic reviews indicate that the objectives of the treatment plan are not being met or that there is evidence of diversion or a pattern of substance abuse. Long-term opioid treatment is associated with the development of tolerance to its analgesic effects. There is also evidence that opioid treatment may paradoxically induce abnormal pain sensitivity, including hyperalgesia and allodynia. Thus, increasing opioid doses may not improve pain control and function.

e. Consultation/referral.

A specialty consultation may be considered at any time if there is evidence of significant adverse effects or lack of response to the medication. Pain, physical medicine, rehabilitation, general surgery, orthopedics, anesthesiology, psychiatry, neurology, rheumatology, oncology, addiction medicine, or other consultation may be appropriate. The physician should also consider consultation with, or referral to, a physician with expertise in addiction medicine or substance abuse counseling, if there is evidence of diversion or a pattern of substance abuse. The board encourages a multidisciplinary approach to chronic pain management, including the use of adjunct therapies such as acupuncture, physical therapy and massage.

f. Documentation.

The physician shall keep accurate, timely, and complete records that detail compliance with this subrule, including patient evaluation, diagnostic studies, treatment modalities, treatment plan, informed consent, periodic review, consultation, and any other relevant information about the patient's condition and treatment.

g. Pain management agreements.

A physician who treats patients for chronic pain with controlled substances shall consider using a pain management agreement with each patient being treated that specifies the rules for medication use and the consequences for misuse. In determining whether to use a pain management agreement, a physician shall evaluate each patient, taking into account the risks to the patient and the potential benefits of long-term treatment with controlled substances. A physician who prescribes controlled substances to a patient for more than 90 days for treatment of chronic pain shall utilize a pain management agreement if the physician has reason to believe a patient is at risk of drug abuse or diversion. If a physician prescribes controlled substances to a patient for more than 90 days for treatment of chronic pain and chooses not to use a pain management agreement, then the physician shall document in the patient's medical records the reason(s) why a pain management agreement was not used. Use of pain management agreements is not necessary for hospice or nursing home patients. A sample pain management agreement and prescription drug risk assessment tools may be found on the board's Web site at [www.medicalboard.iowa.gov](http://www.medicalboard.iowa.gov).

h. Substance abuse history or comorbid psychiatric disorder.

A patient's prior history of substance abuse does not necessarily contraindicate appropriate pain management. However, treatment of patients with a history of substance abuse or with a comorbid psychiatric disorder may require extra care and communication with the patient,

monitoring, documentation, and consultation with or referral to an expert in the management of such patients. The board strongly encourages a multidisciplinary approach for pain management of such patients that incorporates the expertise of other health care professionals.

i. Drug testing.

A physician who prescribes controlled substances to a patient for more than 90 days for the treatment of chronic pain shall consider utilizing drug testing to ensure that the patient is receiving appropriate therapeutic levels of prescribed medications or if the physician has reason to believe that the patient is at risk of drug abuse or diversion.

j. Termination of care.

The physician shall consider termination of patient care if there is evidence of noncompliance with the rules for medication use, drug diversion, or a repeated pattern of substance abuse.

**13.2(6) Pain management for terminal illness.**

The provisions of this subrule apply to patients who are at the stage in the progression of cancer or other terminal illness when the goal of pain management is comfort care. When the goal of treatment shifts to comfort care rather than cure of the underlying condition, the board recognizes that the dosage level of opiates or controlled substances to control pain may exceed dosages recommended for chronic pain and may come at the expense of patient function. The determination of such pain management should involve the patient, if possible, and others the patient has designated for assisting in end-of-life care.

**13.2(7) Prescription monitoring program.**

The Iowa board of pharmacy has established a prescription monitoring program pursuant to Iowa Code sections [124.551](#) to [124.558](#) to assist prescribers and pharmacists in monitoring the prescription of controlled substances to patients. The board recommends that physicians utilize the prescription monitoring program when prescribing controlled substances to patients if the physician has reason to believe that a patient is at risk of drug abuse or diversion. A link to the prescription monitoring program may be found at the board's Web site at [www.medicalboard.iowa.gov](http://www.medicalboard.iowa.gov).

**13.2(8) Pain management resources.**

The board strongly recommends that physicians consult the following resources regarding the proper treatment of chronic pain. This list is provided for the convenience of licensees, and the publications included are not intended to be incorporated in the rule by reference.

a. American Academy of Hospice and Palliative Medicine or AAHPM is the American Medical Association-recognized specialty society of physicians who practice in hospice and palliative medicine in the United States. The mission of the AAHPM is to enhance the treatment of pain at the end of life.

b. American Academy of Pain Medicine or AAPM is the American Medical Association-recognized specialty society of physicians who practice pain medicine in the United States. The mission of the AAPM is to enhance pain medicine practice by promoting a climate conducive to the effective and efficient practice of pain medicine.

c. American Pain Society or APS is the national chapter of the International Association for the Study of Pain, an organization composed of physicians, nurses, psychologists, scientists and other professionals who have an interest in the study and treatment of pain. The mission of the APS is to serve people in pain by advancing research, education, treatment and professional practice.

d. DEA Policy Statement: Dispensing Controlled Substances for the Treatment of Pain. On August 28, 2006, the Drug Enforcement Agency (DEA) issued a policy statement establishing guidelines for practitioners who dispense controlled substances for the treatment of pain. This policy statement may be helpful to practitioners who treat pain with controlled substances.



e. Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain. In March 2007, the Washington State Agency Medical Directors' Group published an educational pilot to improve care and safety of patients with chronic, noncancer pain who are treated with opioids. The guidelines include opioid dosing recommendations.

f. Responsible Opioid Prescribing: A Physician's Guide. In 2007, in collaboration with author Scott Fishman, M.D., the Federation of State Medical Boards' (FSMB) Research and Education Foundation published a book on responsible opioid prescribing based on the FSMB Model Policy for the Use of Controlled Substances for the Treatment of Pain.

g. World Health Organization: Pain Relief Ladder. Cancer pain relief and palliative care. Technical report series 804. Geneva: World Health Organization.

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## **IOWA ADMINISTRATIVE CODE 653—13.9**

### **Standards of practice—interventional chronic pain management.**

This rule establishes standards of practice for the practice of interventional chronic pain management. The purpose of this rule is to assist physicians who consider interventional techniques to treat patients with chronic pain

**13.9(1) Definition.** As used in this rule: "Interventional chronic pain management" means the diagnosis and treatment of pain-related disorders with the application of interventional techniques in managing subacute, chronic, persistent, and intractable pain. Interventional techniques include percutaneous (through the skin) needle placement to inject drugs in targeted areas. Interventional techniques also include nerve ablation (excision or amputation) and certain surgical procedures. Interventional techniques often involve injection of steroids, analgesics, and anesthetics and include: lumbar, thoracic, and cervical spine injections, intra-articular injections, intrathecal injections, epidural injections (both regular and transforaminal), facet injections, discography, nerve destruction, occipital nerve blocks, lumbar sympathetic blocks and vertebroplasty, and kyphoplasty. Interventional chronic pain management includes the use of fluoroscopy when it is used to assess the cause of a patient's chronic pain or when it is used to identify anatomic landmarks during interventional techniques. Specific interventional techniques include: SI joint injections; spinal punctures; epidural blood patches; epidural injections; epidural/spinal injections; lumbar injections; epidural/subarachnoid catheters; occipital nerve blocks; axillary nerve blocks; intercostals nerve blocks; multiple intercostals nerve blocks; ilioinguinal nerve blocks; peripheral nerve blocks; facet joint injections; cervical/thoracic facet joint injections; lumbar facet injections; multiple lumbar facet injections; transforaminal epidural steroid injections; transforaminal cervical steroid injections; sphenopalatine ganglion blocks; paravertebral sympathetic blocks; neurolysis of the lumbar facet nerve; neurolysis of the cervical facet nerve; and destruction of the peripheral nerve.

### **13.9(2) Interventional chronic pain management.**

The practice of interventional chronic pain management shall include the following:

- a. Comprehensive assessment of the patient;
- b. Diagnosis of the cause of the patient's pain;
- c. Evaluation of alternative treatment options;
- d. Selection of appropriate treatment options;
- e. Termination of prescribed treatment options when appropriate;
- f. Follow-up care; and

g. Collaboration with other health care providers.

**13.9(3) Practice of medicine.**

Interventional chronic pain management is the practice of medicine.

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**IOWA ADMINISTRATIVE CODE 653-11.4**

**Continuing education requirements for Iowa-licensed physicians**

d. Training for chronic pain management for permanent or special license renewal.

The licensee shall complete the training for chronic pain management as part of a category 1 credit. The licensee may utilize category 1 credit received for this training during the license period in which the training occurred to meet continuing education requirements in paragraph [11.4\(1\) "a."](#)

(1) A licensee who regularly provides primary health care to patients in Iowa must complete at least two hours of category 1 credit for chronic pain management every five years. "A licensee who regularly provides primary health care to patients" means all emergency physicians, family physicians, general practice physicians, internists, neurologists, pain medicine specialists, psychiatrists, and any other physician who regularly provides primary health care to patients.

(2) A licensee who had a permanent license on August 17, 2011, has until August 17, 2016, to complete the chronic pain management training, and shall then complete the training once every five years thereafter.

e. Training for end-of-life care for permanent or special license renewal.

The licensee shall complete the training for end-of-life care as part of a category 1 credit. The licensee may utilize category 1 credit received for this training during the license period in which the training occurred to meet continuing education requirements in paragraph [11.4\(1\) "a."](#)

(1) A licensee who regularly provides primary health care to patients in Iowa must complete at least two hours of category 1 credit for end-of-life care every five years. "A licensee who regularly provides primary health care to patients" means all emergency physicians, family physicians, general practice physicians, internists, neurologists, pain medicine specialists, psychiatrists, and any other physician who regularly provides primary health care to patients.

(2) A licensee who had a permanent license on August 17, 2011, has until August 17, 2016, to complete the end-of-life care training, and shall then complete the training once every five years thereafter.

**NOTE: This is a sample pain management agreement offered by the Iowa Board of Medicine for physicians who prescribe controlled substances to patients with chronic pain. Iowa Administrative Rule 653—13.2(5)“g” encourages physicians to use agreements that specify the use of pain control medications and the consequences for misuse.**

## **PAIN MANAGEMENT AGREEMENT**

- 1. PURPOSE:** The purpose of the Pain Management Agreement (Agreement) is to prevent misunderstandings about certain controlled medications you will be taking for pain management. This is to help both you and your physician (provider) to comply with the law regarding controlled medications. I understand that this Agreement is essential to the trust and confidence necessary in a physician/patient relationship and that my physician undertakes to treat me based on this Agreement.
- 2. VIOLATION:** I understand that if I break this Agreement, my provider will stop prescribing these pain control medications, and may terminate my care. In this case, my provider may choose to taper me off of my medications, or discontinue medications and prescribe medication to treat the withdrawal symptoms. This choice will be made by my provider.
- 3. COMMUNICATION:** I will communicate fully with my provider about the character and intensity of my pain, the effect that my pain has on my daily life, and how well the medications are helping to relieve my pain.
- 4. ILLEGAL DRUGS PROHIBITED:** I will not use illegal drugs, including marijuana, heroin, cocaine, etc.
- 5. DRUG DIVERSION PROHIBITED:** I will not share, sell or trade my medications to anyone. Altering a prescription in any manner, selling medications, or misrepresenting myself to a pharmacy is a felony and will be reported to the police.
- 6. SINGLE PROVIDER:** I will not attempt to obtain controlled medications, including opioid pain management medications, controlled stimulants, or anti-anxiety medications from any other physician.
- 7. PROTECTING MEDICATIONS:** I will safeguard my medications from loss or theft. Lost or stolen medications **will not** be replaced. To reduce instances of medication loss/theft, carry only the amount of medications that you will be using when away from home.
- 8.** I agree to use the following pharmacy for all of my pain control medication prescriptions:

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(PRINT NAME OF PHARMACY, ADDRESS, AND TELEPHONE NUMBER.)

- 9. REFILLS:** I agree that requests for renewals of my prescriptions for pain control medications will be made at the time of an office visit or during regular office hours of my provider. If you fail to come to a scheduled appointment without notifying us **prior** to that appointment you will not be given a refill until you are seen. **No renewals will be available under any circumstances during the evenings or on the weekends.**

- 10. PERMISSION TO CONTACT PATIENT REFERENCES:** I agree that my provider or authorized staff member may contact one or more of the references I have provided on a separate form to discuss my history and medical care at any time during the course of my treatment.
- 11. PERMISSION TO CONTACT PREVIOUS PHYSICIAN AND PHARMACY:** I agree that my provider or authorized staff member may contact my previous physician(s) and/or my previous pharmacy to discuss my history and medical care at any time during the course of my treatment.
- 12. PRESCRIPTION MONITORING PROGRAM:** I am fully aware that my provider may review my controlled substance prescription records in the Iowa Prescription Monitoring Program operated by the Iowa Board of Pharmacy at any time during the course of my treatment to determine whether I have obtained prescriptions from other providers.
- 13. COOPERATION WITH INVESTIGATIONS:** I authorize the provider and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the State Board of Pharmacy in the investigation of any possible misuse, sale, or other diversion of my pain control medications. I authorize my provider to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right or privacy or confidentiality with respect to these authorizations.
- 14. DRUG TESTING:** I agree to submit to a blood or urine test at my cost if requested by my provider to determine my compliance with my program of pain control medications. Refusal to submit to this test will result in the immediate termination of my care by the provider.
- 15. MISUSE OF MEDICATIONS:** I agree that I will use my pain control medications at a rate no greater than the prescribed rate and that use of my medication at a greater rate will result in my being without medications for a period of time. Continued misuse of pain control medications will result in termination of my care from this provider.
- 16. HOSPITALIZATION:** If you are hospitalized while under the care of the provider and have questions for our providers, your hospital nurse taking care of you will call the clinic. You are not to call the clinic when you are hospitalized.
- 17. UNDERSTANDING THIS AGREEMENT:** I agree that all terms of this Agreement have been fully explained to me and I understand all terms of this Agreement. All of my questions and concerns regarding treatment have been adequately answered. Copies of this signed Agreement will be given to me and placed in my medical record.

**THIS AGREEMENT IS ENTERED INTO ON THIS DATE:** \_\_\_\_\_

**PATIENT SIGNATURE:** \_\_\_\_\_

**PROVIDER SIGNATURE:** \_\_\_\_\_

**WITNESSED BY:** \_\_\_\_\_

ISSUED: 2012.