AlohaCare
*Aloha is the difference*

# QUEST Pain Medication Agreement

## Oxycodone CR (OxyContin®)

Pharmacy Services Fax: 973-6327, Toll Free Fax (877)316-6376

| NAME: | Member ID#: | DOB: |
|---|---|---|

I, _____, **agree to the following rules and conditions about new prescriptions and refills for oxycodone CR (OxyContin®):**
(*print member name*)

1. I will limit the amount I take as prescribed by my doctor. I will discuss any changes in the amount I take with my doctor.
2. I am responsible for my medications. Lost, misplaced, damaged, or stolen medications will not be replaced.
3. I understand I will not sell, lend, share or give any of my medication to others.
4. Refills are only in the amount my doctor prescribes. Early fills are not allowed. Refills are not allowed after hours, on weekends or on holidays.
5. I will not request for more medication for pain from other doctors.
6. I will tell my doctor of all medications that I am taking.
7. I understand that my doctor may stop prescribing oxycodone CR (OxyContin®) or change the treatment plan if I do not show any improvement in pain.
8. I will consent to random drug testing to assure that I am only taking prescribed drugs. If I am found positive for illegal drugs, my doctor may stop prescribing oxycodone CR (OxyContin®).
9. Vacation fills will only be allowed for up to 90 days. A copy of the plane ticket showing departure and arrival date must be submitted with the oxycodone (OxyContin®) Drug Coverage Request form requesting the vacation fill.
10. I understand that failure to comply with any of these conditions or failure to make regular follow-up appointments with my primary care provider may result in termination of oxycodone CR (OxyContin®) prescriptions.

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NOTE TO PROVIDER:

- Please be sure to provide the member with a copy of the signed agreement and renew this agreement with AlohaCare annually.
- Keep your signed original in the patient file and fax a copy to AlohaCare at **(808) 973-6327** or toll free **(877) 316-6376.**

Print Provider Name: _____

Provider Signature: _____ Date: _____

Member Signature: _____ Date: _____