

PLACE LABEL HERE



FAMILY HEALTH CENTERS  
OF SAN DIEGO

## **MAT Treatment Agreement for Naltrexone (Vivitrol® extended-release injectable suspension)**

*As a participant in naltrexone (Vivitrol®) treatment for opioid use disorder, I agree to the following:*

1. I agree to complete and sign all necessary releases of information for my health records with FHCSO, to permit coordination of my healthcare within FHCSO and with outside treatment providers, when necessary.
2. I agree to participate in an assessment of my needs for substance use treatment, medical and/or mental health services.
3. I agree my goal is to stop misusing addictive and/or illicit drugs during my treatment with naltrexone (Vivitrol®).
4. I agree to arrive 30 minutes early for all scheduled appointments or notify FHCSO in advance to reschedule, except in case of emergency. I understand that appointments with providers may need to be rescheduled if I arrive late.
5. I agree to submit urine screens prior to each scheduled medication appointment. I will submit to scheduled and/or random testing including observed urine screens upon request. Failure to comply will result in notation of a positive urine screen in my health record.
6. I understand naltrexone (Vivitrol®) without counseling is not sufficient treatment for my substance use disorder. I agree to participate in counseling, as discussed and agreed upon with my healthcare provider(s). I understand my participation in counseling is required to continue to receive Vivitrol.
7. I agree to establish an individualized treatment plan and regularly assess progress towards goals with my primary counselor.
8. I agree to attend sober support meetings, if assigned, such as Alcoholics Anonymous, Narcotics Anonymous, SMART Recovery®, religious affiliations, etc.
9. **I understand my naltrexone (Vivitrol®) will only be given at scheduled appointments.** A missed appointment may result in my waiting until the next scheduled visit to get my naltrexone (Vivitrol®). I understand early administration of my naltrexone (Vivitrol®) is not possible.
10. I agree not to sell, share, give or buy illicit drugs at any FHCSO facility, parking lot, or surrounding neighborhood.
11. I understand naltrexone (Vivitrol®) is currently indicated and approved by the FDA for alcohol use disorder and opioid use disorder.
12. I understand I should not be on naltrexone (Vivitrol®) if I have acute infectious hepatitis.
13. I understand the risks of naltrexone (Vivitrol®) during pregnancy are unknown and naltrexone (Vivitrol®) may not be recommended.
14. I understand I must abstain from opiates for a minimum of two (2) weeks before starting

PLACE LABEL HERE



FAMILY HEALTH CENTERS  
OF SAN DIEGO

naltrexone (Vivitrol®). Opiates include legal pain killers such as Oxycontin®, Methadone, Hydrocodone, Morphine, Vicodin®, Fentanyl, Duragesic, or others, or illegal opiates such as heroin.

15. Once injected, I understand I may experience acute opiate withdrawal symptoms if I still have opiates in my body, even if I've abstained for two (2) weeks. Opiate withdrawal symptoms include runny nose, anxiety, nausea, vomiting, abdominal pain, diarrhea, muscle aches and pain, which may be severe in some cases.
16. I understand I may experience symptoms such as nausea, vomiting, and abdominal pain if I have consumed alcohol less than one (1) week before the first naltrexone (Vivitrol®) dose.
17. I understand once injected, naltrexone (Vivitrol®) cannot be removed and will be deposited in muscle tissue for up to one month.
18. I understand common side effects are nausea, vomiting, headache, dizziness and tiredness, and redness, induration, pain and discomfort at the injection site. If problems occur, they can last up to 30 days.
19. I understand naltrexone (Vivitrol®) has been associated with abnormal liver function and I may need to undergo periodic blood tests to monitor my liver.
20. I understand if I sustain an injury, which may require treatment with opiates; it may be more difficult to treat my pain because of naltrexone (Vivitrol®) blocking the opiate pain receptors.
21. I understand naltrexone (Vivitrol®) may lower tolerance for opioids, resulting in a greater sensitivity to lower doses of opioids after injectable naltrexone (Vivitrol®) treatment has occurred or has been discontinued. I understand that use of opioids in this setting may result in accidental overdose and death.
22. **I understand if I attempt to reverse the purpose of naltrexone (Vivitrol®), which is to block the brain opiate receptors, with the use of opiates, I run the risk of accidental overdose and death.**
23. I understand naltrexone (Vivitrol®) treatment does not neutralize the intoxication or impairment caused by drinking alcohol. If I drink and drive, I will still be considered impaired and under the influence of alcohol. The legal and safety consequences of operating a motor vehicle above the legal limit will still apply.
24. I agree violating any part of this treatment agreement may result in no longer receiving treatment with naltrexone (Vivitrol®), and/or I may be referred to another level of care.
25. I agree to follow all FHCS D policies and I understand violations of FHCS D policies may result in my discharge from the MAT program and/or FHCS D.
26. I understand it is important to inform medical personnel that I am taking naltrexone (Vivitrol® extended-release injectable suspension). I agree to carry or wear a medical alert (card, bracelet, dog tags). A patient wallet card or medical alert bracelet can be ordered from 1-800-848-4876, Option #1.
27. I understand my success in treatment may include, but is not limited to, freedom from intoxication, improved physical and psychosocial functioning, and adherence to the

PLACE LABEL HERE



FAMILY HEALTH CENTERS  
OF SAN DIEGO

treatment plan.

I have read and understand these details about naltrexone (Vivitrol®) treatment. Any questions I had were fully answered and understood by me. I consent to be treated with naltrexone (Vivitrol®).

\_\_\_\_\_  
Patient Signature

Date\_\_\_\_\_

\_\_\_\_\_  
Print Name

Date\_\_\_\_\_

\_\_\_\_\_  
Physician Signature

Date\_\_\_\_\_

\_\_\_\_\_  
Print Name

Date\_\_\_\_\_