El Dorado Community Health Centers
Placerville • Diamond Springs • Cameron Park

Vivitrol Plan of Care Agreement

Patient Initial Each Item:

_____1. I understand the frequency of visits will be weekly at first and then biweekly. As my recovery progresses, my visits may extend out to 4 weeks. I understand that if I relapse or miss appointments then I will return to weekly visits until assurance in my recovery is reestablished. I must call 24 hours prior to canceling an appointment. If I miss an appointment without contacting my provider. I may be asked to return to more frequent visits, may not have my medication refilled until I am seen again, and I may be discharged. I understand that if I am not seen in the office as prescribed by my provider, I will be unable to obtain my prescription since the injection is coordinated with monthly visits.

_____2. I agree to have my Vivitrol Rx sent directly to the EDCHC facility. It will be injected on site by my C3 provider or nursing team.

_____3. I agree not to take any other medications with Vivitrol without prior permission from my C3 provider.

_____4. I understand the goal of treatment for alcohol and opioid dependency is to learn to live without abusing alcohol and drugs. Vivitrol injections should continue as long as necessary to prevent relapse.

_____5. I will submit a urine specimen (my own urine) for drug screen (narcotic, cocaine, amphetamine, alcohol, benzodiazepine, and others) upon my providers request as often as directed.

_____6. I understand that if I have previously used opioids, I may be more sensitive to lower doses of opioids and at risk of accidental overdose if I use opioids when my next dose is due, if I miss a dose, or after Vivitrol treatment is discontinued. It is important that I inform family members and people close to me of this increased sensitivity to opioids and the risk of overdose. I understand that because Vivitrol can block the effects of opioids, I may not perceive any effect if I self-administer heroin or any other opioid drug in small does while on Vivitrol. Further, I understand that administration of doses of heroin or any other opioid to try to bypass the blockade and get high while on Vivitrol may lead to serious injury, coma, or death. I understand that overdose deaths have occurred in the cases where opioid tolerant patients have tried to "override" the blocking action of Vivitrol with larger doses of opioids (even at doses previously tolerated).

_____7. I understand that I may not experience the expected effect from opioid-containing analgesic, antidiarrheal, or other antitussive (anti-cough) medications.

_____8. I understand that a reaction at the site of Vivitrol injection may occur. Reactions include pain, tenderness, induration, swelling, redness, bruising and itching. Serious injection site reactions including tissue death may occur. Some of these injection site reactions have required surgery. I should seek medical attention for worsening skin reactions.

_____9. I understand that I need to be off all opioids, including opioid-containing medicines, for at least 7-14 days before starting Vivitrol in order to avoid precipitation of opioid withdrawal. If I am transitioning from buprenorphine or methadone, I may be at risk for withdrawal for as long as two weeks. I understand that withdrawal caused by an opioid antagonist (Vivitrol) may be severe enough to require hospitalization if I have not been opioid-free for a sufficient number of days, and the withdrawal is different from the experience of spontaneous withdrawal that occurs with discontinuation of opioid in a dependent individual. I am not to take Vivitrol if I have any symptoms of opioid withdrawal. I understand that it is absolutely imperative that I notify my healthcare provider of any ALCOHOL dependence or of any recent use of opioids, or any history of opioid dependence before starting Vivitrol in order to avoid precipitation of opioid withdrawal.

_____10. I understand that Vivitrol may cause liver injury and I need to notify my healthcare provider if I develop symptoms and or signs of liver disease.

_____11. I understand that I may experience depression while taking Vivitrol. It is important that I inform family members and people close to me that I am taking Vivitrol and that they should call a doctor right away if I become depressed or experience symptoms of depression.

_____12. I understand that Vivitrol may cause an allergic pneumonia. I should immediately notify my physician if I develop signs and symptoms of pneumonia, including shortness of breath, coughing or wheezing.

_____13. I understand that I may experience nausea/vomiting following the initial injection of Vivitrol. These episodes of nausea tend to be mild and subside within a few days' post-injection. Nausea is less likely with subsequent injections. I may also experience tiredness, headache, vomiting, decreased appetite, painful joints and muscle cramps.

_____14. I understand that dizziness or fainting may occur with Vivitrol treatment and I should avoid driving or operating heavy machinery until I have determined how Vivitrol affects me.

_____15. I understand other side effects include muscle cramps, somnolence or sedation, anorexia, decreased appetite or other appetite disorder, an elevation in eosinophils which resolves over time (and in rare instances eosinophilic pneumonia), inflammation of my nose and throat, insomnia, and toothache.

_____16. I understand that Vivitrol is contraindicated in individuals with acute hepatitis or liver failure, fulminant AIDS, opioid positive drug screens and any individual who have previously exhibited hypersensitivity to naltrexone, PLG (polylactide-co-glycolide), carboxymethylcellulose or any other component of the diluent.

_____17. I understand that once Vivitrol is injected, it is not possible to remove it from my body.

_____18. I understand that the use of Vivitrol is a form of Medication Assisted Therapy (MAT) helping me stay sober while I receive the appropriate psychotherapy needed for long term recovery. Vivitrol has been shown to treat alcohol and opioid dependence only when used as part of a treatment program that includes counseling and support. We advise two NA/AA meetings per week and group therapy and/or one on one therapy.

_____19. I understand that I am to notify my C3 provider if I am breast-feeding, if I become pregnant, if I think I might be pregnant, or if I am thinking about becoming pregnant.

_____20. I allow my provider to communicate with other providers regarding my medical care, consistent with HIPAA guidelines. Treatment disclosure may include, but is not limited to, discussing my medications with the pharmacist. I understand that records released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may contain confidential information about communicable diseases including Hepatitis, HIV(AIDS) or related illnesses.

_____21. I allow C3 to receive information from any pharmacy I have used.

_____22. I understand that rude or disrespectful treatment of staff is not tolerated and may result in my discharge. (Ex: using profanity, raising my voice, making vulgar or inappropriate comments).

_____23. I understand that I must provide a viable contact number at all times (and will update the office of any changes) or my provider may not prescribe medications.

_____24. I understand the commitment to the program and the many appointments, therefore transportation cannot be an issue or a reason for short notice cancellations or no show appointments.

_____25. Regarding alcohol: I understand that I am required to not have used alcohol or alcohol containing products for the past 4 days and that I am not having any signs of Delirium Tremens (DT's). I understand that DT's may be life threatening and if any signs occur I will call 911.

_____26. Regarding opioids: I understand that I must be opioid drug free (detoxed) for 7 days and for 14 days detoxed from Methadone and Buprenorphine. If I am not detoxed than the Vivitrol injection will precipitate immediate and sometimes severe opioid withdrawal (to include but not limited to nausea, vomiting, muscle cramps, tremors, headache and sweating).

_____27. I understand that I need to carry documentation to alert medical personnel to the fact that I am taking Vivitrol (naltrexone for extended-release injectable suspension). This is important information if I need to obtain medical treatment in an emergency and am unable to tell other health care providers that I am on Vivitrol. I agree to wear a medical alert (card, bracelet, dog tags).

I have read and understand all the information about Vivitrol treatment. I have received answers to any questions I have. I agree that I am responsible to abide by these instructions. I wish to be treated with Vivitrol.

Name: _____ Date of Birth: _____

Patient Signature:_____ Date: _____

[1] Created on 2/20/19