

## CONSENT FOR TREATMENT WITH NALTREXONE

### Oral Naltrexone (Revia) and Extended-Release Injectable Naltrexone (Vivitrol)

Naltrexone is a prescription medication that is used to:

- Prevent relapse to opiate/opioid use
- Treat alcoholism

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You cannot start naltrexone now if you:

- Are currently using opiates/opioids
- Are currently having withdrawal from opiate/opioid use

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It is necessary to stop all drugs/medications that have any opiates/opioids in them 7–10 days before starting naltrexone to avoid getting sick. It is also important that you NOT have any opioids (such as: methadone, buprenorphine, heroin, oxycodone, ultram, etc.) in your body and NOT be currently withdrawing when you begin treatment.

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Urine drug screens will be done before each injection to assure abstinence from opioids.

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Because extended-release naltrexone (Vivitrol) is an injection, it cannot be taken out of the body. To make sure there are no allergies, all patients who have never taken this medication must begin with a dose by mouth (tablet form). If you are not allergic to the tablet, you can move on to the injection.

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A reaction at the site of injection may occur that may be serious. It is important to get medical attention for reactions that get worse or that you are unsure of, including the following:

- Intense pain
- Area feels hard, lumpy
- Swelling, redness, and warmth
- Blisters and/or open skin

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Allergic reactions can happen soon after an injection of naltrexone. Tell your provider or get immediate medical help if you have any of these symptoms:

- Skin rash
- Chest pain
- Trouble breathing or wheezing
- Dizziness or fainting
- Swelling of eyes, mouth, tongue, or face

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Because naltrexone can affect your liver, blood will be drawn before starting treatment to check the levels and then as needed during treatment to make sure your liver is healthy. If you develop any symptoms during treatment such as:

- Yellowing of the skin or eyes
- Dark urine
- More tired than normal
- White stool or diarrhea
- Stomach pain or loss of appetite

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You should contact your doctor or be seen by a medical provider and tell them about the medication you are taking.

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You may experience depression while on naltrexone. If you develop depression, it is important to tell someone and/or alert your medical providers. If you feel like harming yourself or someone else, you should go to your local emergency room or call 911 if you cannot reach your medical providers.

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You may develop signs/symptoms of pneumonia on this medication:

- Shortness of breath
- Wheezing
- Difficulty breathing
- Fever
- Cough that doesn't go away

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If so, please go to your local emergency room or call 911 if you are not physically able to do so.

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Dizziness may occur on naltrexone treatment. You should avoid driving or operating heavy or dangerous machinery until you are sure how Vivitrol affects you.

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Use of large doses of heroin or other opiates/opioids (morphine, oxycodone, Percocet, OxyContin, methadone, codeine, etc.) while on Vivitrol could cause serious injury, coma, or death.

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If you were addicted to opioids/opiates before naltrexone, you **Will** be more sensitive to lower doses of opioids/opiates and at **Risk** for an **Overdose** should you have a relapse.

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Relapse to opioids is very dangerous after being on naltrexone. Do not start using what you used before starting naltrexone because your body will be more sensitive to opiates. Alert your family, friends, or close contacts that you are on Vivitrol and about the risk of an overdose should you have a relapse.

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You should carry alert information so others know you are on naltrexone in a medical emergency: medical alert necklace, bracelet, and/or emergency card. \_\_\_\_\_

For all women of childbearing age: a pregnancy test will be completed before treatment has begun and then before each next injection. If you learn you are pregnant at any time, please alert your medical team. \_\_\_\_\_

You will see your treatment team frequently in the beginning and then less frequently as you become more stable. However, it is important to be followed closely for support and assessment. During your treatment you should expect the following:

- Urine drug screens at visits
  - Clinical check-ins
  - Check in: social supports/recovery network
  - Provider visits
  - Blood work as indicated
  - Monthly injections
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Naltrexone treatment is only one part of your treatment. It is important that you seek counseling support services along with the medical part of your treatment to assist you in your recovery process. \_\_\_\_\_

In an emergency situation, if you require pain management with opioid medications, it is important that your medical team know that you are on naltrexone. You would require medical management by providers trained in the use of anesthetic drugs and management of potential respiratory effects. Carry emergency contact information with you at all times and have your team contacted if needed to assist in your care. \_\_\_\_\_

**For patients 18 years of age and older:**

**PATIENT**

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**WITNESS**

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**For patients under 18 years of age seeking treatment with parental consent:**

**PATIENT**

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**PARENT/GUARDIAN**

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**WITNESS**

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**For patients under 18 years of age seeking treatment without parental consent and (i) a “mature minor” or (ii) an “emancipated minor”**

**PATIENT**

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**PROVIDER**

\_\_\_\_\_  
Treating Provider Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**WITNESS**

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**For patients 12-17 years of age diagnosed with a substance use disorder by two or more providers, seeking treatment related to diagnosis without parental consent**

**PATIENT**

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**PROVIDER 1**

\_\_\_\_\_  
Diagnosing Provider Name 1

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**PROVIDER 2**

\_\_\_\_\_  
Diagnosing Provider Name 2

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**WITNESS**

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**After completion, scan form into patient record and provide a copy to the patient.**

**Note: This form reflects Massachusetts state laws related to consent for substance use disorder treatment. Providers should be aware of the legal requirements for consent in their own individual states and amend accordingly.**

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