North Tyneside Stop Smoking Service

Stop Smoking and Medicines Protocol – 2014/15

For use by pharmacy practice staff participating in the Stop Smoking Service scheme only:

1. Consultation

- Check patient is entitled to access the scheme
- Perform consultation with patient in consultation area on a one to one basis for 4 weeks from the quit attempt.
- Provide on-going support between 4-12 weeks, at least once every 2 weeks via 1-1, text or phone if appropriate.

2. NRT

- Provide NRT if appropriate and complete patient details on the NRT supply forms.(see appendix 3)
- NRT supply form must be signed by the patient and evidence of eligibility must be checked.
- Complete NRT supply forms – 1 form per client per week and up to 12 weeks supply can be issued and must be retain in the pharmacy for audit purposes.
- Items supplied which are not on the formulary will not be reimbursed.
- NRT supplied should be claimed for payment via the NRT supply module on Pharm Outcomes. Invoices will be generated and emailed to Finance Department, North Tyneside Council automatically.

3. Champix and Zyban

- Clients requiring Champix or Zyban must be referred to their GP using the letter of recommendation to supply. The decision to prescribe drug treatments lies with the GP. (see Appendix 1 & 2)
- The stop smoking advisors are required to maintain a record of all pharmacotherapy and complete a yellow card if there is an adverse reaction reported.

4. 4-Week monitoring data

- 4 week data must be entered onto Pharm Outcomes. Data must be entered immediately and not accumulated in the pharmacy as this may result in payments being delayed or not paid.

- Claims for support provided will be automatically generated by Pharm Outcomes and emailed to the Finance Department, North Tyneside Council.

5. Contact details:

Any queries regarding the stop smoking service please contact:

North Tyneside Stop Smoking Service on –0191- 643 2105

Or Ann Gunning, LPC ,– 07832 967622

Appendix - 1

(Insert Address/stamp)

(Insert Date)

NHS No:
Patients Name:
Address:
DOB:

Dear Dr

I am a stop smoking advisor and I am providing support to the above patient to stop smoking as part of a structured stop smoking service offered through pharmacies. We have discussed the various treatment options and they have expressed preference for Varenicline/Bupropion (Delete as appropriate) to support their quit attempt.

If this treatment is clinically appropriate, please provide the patient with a prescription for:

☐ Starter pack of Varenicline, contains 11 x 0.5mg tablets and 14 x 1mg tablets.

☐ 30 Bupropion 150mg tablets to allow initial titration and patient to reach their quit date

Further advice will be provided of the client's progress in attempt to quit.

Please do not hesitate to contact me should you require further information

Yours sincerely,

Stop Smoking Advisor

Appendix 2

Date:……

Dear

Request for Prescription Medication

Name: ……..……..…… Date of Birth ……

The above patient is progressing successfully with a treatment programme to stop smoking and continues to refrain from smoking.

Could you please provide a **further prescription for**:

☐ **A two week supply of Champix (maintenance pack)** *1mg twice daily*
The patient has not expressed any concerns over side effects therefore if there has been no change to the patients medical and clinical condition, could you please provide a further prescription

☐ **A four week prescription for Bupropian** *150mg twice daily*
The patient has not expressed any concerns over side effects therefore if there has been no change to the patients medical and clinical condition, could you please provide a further prescription

I am acting as the Stop Smoking Advisor, and will keep you informed of the patient's progress.

Yours sincerely

Signature ……

Print Name ……...

Stop Smoking Advisor

SMOKEFREE

Appendix 3

(Insert Address/stamp)

(Insert Date)

NHS No:
Patients Name:
Address:
DOB:

Dear Dr

☐ I would like to advise you that your patient has completed their course of Varenicline/Bupropion and has stop smoking since .....

☐ I would like to advise you that your patient did not succeed on this occasion in their attempt to stop smoking.

☐ I would like to advise you that your patient experienced side effects related to Varenicline/Bupropion and has stop taken this medication.

Please do not hesitate to contact me should you require further information

Yours sincerely,

Stop Smoking Advisor

SMOKEFREE

Appendix 3

NRT Supply Form North Tyneside

Client's Name _____

Address _____

Postcode _____ **DOB** _____

NI Number: _____ **Male** ☐ **Female** ☐

Client Reference Number: ☐

Week No: ☐ **(Only 2 Products To Be Given Per Week)**

Product	Strength (**Please Circle**)	Qty
Nicotinell Patches (24 Hour)	21mg 14mg 7mg	
Nicorette Invisi Patches (16 Hour)	25mg 15mg 10mg	
Niquitin Lozenges	4mg 2mg	
NiQuitin Minis Lozenges	4mg 1.5mg	
Nicorette sugar-free Gum	4mg 2mg	
NRT Inhalator	15mg cartridges	
Sublingual tablets	2mg	
Nicorette Quickmist	1mg	

All Paper work must be retained by the pharmacy for audit purposes

NHS ☐ ☐

Exemption Declaration

Please indicate exemption category (Using **'X'** Mark)

A		**Is under 16 years of age**
B		**Is 16, 17 or 18 and in full-time education**
C		**Is 60 years of age or over**
D		**Has a maternity exemption certificate**
E		**Has a medical exemption certificate**
F		**Has a prescription prepayment certificate**
G		**Has a valid War Pension exemption certificate**
L		**Is named on a current HC2 charge certificate**
H		**Gets income support**
K		**Gets income based jobseekers allowance (JSA(IB))**
M		**Is entitled to, or named on, a valid NHS Tax Credit Exemption Certificate**
S		**Has a partner who gets Pension Credit guarantee credit (PCGC)**

Pay - I have paid

I declare that the information I have given on this form is correct and complete. I understand that if it is not, appropriate action may be taken. I confirm proper entitlement to exemption. To enable the NHS to check I have a valid exemption and to prevent and detect fraud and incorrectness, I consent to the disclosure of relevant information from this form to and by, the NHS Business Services Authority, the Department of Work and Pensions and Local Authorities.

Clients Signature..... Date……..

Pharmacist's Signature: ... . Name: ..... GPhC No: .....Date:..... Version RC 2	*Pharmacy Stamp*