medSask
YOUR MEDICATION INFORMATION SERVICE

TOBACCO CESSATION PRESCRIBING – PATIENT ASSESSMENT RECORD

Patient

Name:	HSN:
Address:	Declaration of consent: I agree to receive tobacco cessation services from my pharmacist and allow my information to be released to or from another healthcare provider as necessary for my care. **Signature:** _____
DOB: o Under 18 years of age → Refer	
Telephone:	Gender: o male o female o other
Email:	o Pregnant o Breastfeeding

Patient Medical History

o **Conditions Associated with Tobacco Use**

- o Angina / heart disease / stroke
- o High blood pressure
- o Elevated cholesterol levels
- o Family history of heart disease
- o Asthma
- o COPD (chronic bronchitis / emphysema)
- o GI: heartburn, ulcers

o **Other medical conditions:**

o **Contraindications / cautions for cessation medications**

- o Liver disease *(if severe, bupropion)*
- o Kidney disease (*reduce varenicline dose)*
- o Unstable psychiatric illness including history of suicidal ideation and/or attempt *(buproprion, varenicline)*
- o History of anorexia or bulimia *(bupropion)*
- o History of seizures *(bupropion)*
- o Unstable cardiovascular disease including serious arrhythmias, persistent or worsening angina, heart attack within the previous 14 days *(NRT)*

Medications (Rx, OTC, herbal) / drug allergies:

Review of Patient's Smoking / Tobacco Use

How long have you smoked regularly? _____

What is the average number of cigarettes you smoke per day? _____

Do you use tobacco other than cigarettes? o No o Yes à Type? _____ Quantity/day _____

Have you tried to quit smoking/tobacco before? o No o Yes à please answer the following:

How many times have you tried to quit? _____

When was your last attempt? _____

Why did you start smoking again? _____

What is the longest period of time you remained tobacco free? _____

What methods have you used before to quit smoking? (ie: cold turkey, reduce to quit, support group, counseling, acupuncture, virtual cigarettes, nicotine replacement therapy, bupropion SR, varenicline, combination therapy): _____

If cessation medications were used, complete this table:

Type of Medication Used	**Efficacy (How well did it work?)**	**# of Weeks Used**	**Reason(s) for Stopping**	**Any Side Effects**
Nicotine Patch (7mg, 14mg, 21mg)				
Nicotine Gum (2mg, 4mg)				
Nicotine Inhaler				
Nicotine Lozenge 1mg, 2mg, 4mg				
Nicotine Mist				
Bupropion SR (Zyban®)				
Varenicline (Champix®)				
Other:				

What are your main concerns about quitting?

- o Dealing with stress
- o Fear of failure
- o Loss of enjoyment
- o Withdrawal symptoms
- o Weight gain
- o Cravings / breaking habit
- o Other _____

Do other members of your household smoke? o No o Yes

Review of Symptoms

Are chronic medical conditions (if any) appropriately treated and controlled?

o Yes à proceed to treatment o No, consult or refer patient to physician or nurse practitioner*

Any other physical signs/symptoms of concern?

o No à proceed to treatment o Yes, consult or refer patient to physician or nurse practitioner*

**Tobacco cessation pharmacotherapy may still be appropriate*

Treatment Selection

1. Non-pharmacological treatments:

o PACT counseling, Cessation Support Program, Spiritual/Religious/Cultural Support, Cold Turkey Approach, Other

2. OTC Nicotine Replacement Therapy: (Check contraindications, cautions for specific formulations)

o Patch, Gum, Inhaler, Lozenge, Spray – reduce to quit, monotherapy or combination therapy

3. Prescription Drug Therapy (Check one)

Rationale for prescribing: Smoking/Tobacco Cessation

o Bupropion SR 150mg PO daily x 3 days; then 150mg PO BID until end of treatment (Total treatment duration = 12 weeks; Quit smoking 1-2 weeks after starting bupropion SR) *(Avoid Bupropion SR if seizure disorder/anorexia)*
Total Quantity: 165 (165 x 150mg tablets)
**Must dispense Zyban® brand for the assessment fee to be covered by DPEBB*

o Varenicline 0.5mg PO daily x 3 days; then 0.5mg PO BID x 4 days; then 1mg PO BID until end of treatment
(Total treatment duration = 12 weeks; Quit smoking 1-2 weeks after starting varenicline)
Total Quantity: 165 (11 x 0.5mg tablets and 154 x 1mg tablets). May provide 1 refill (24 weeks total) if additional therapy needed.

o Varenicline 0.5mg PO daily x 3 days; then 0.5mg PO BID until end of treatment*
(Total treatment duration = 12 weeks; Quit smoking 1-2 weeks after starting varenicline)
Total Quantity: 165 (165 x 0.5mg tablets). May provide 1 refill (24 weeks total) if additional therapy needed.
**Use this dosing option if CrCl < 30 ml/min, adverse effects with higher dose regimen, geriatric patient*

Counseling o **May have prescription filled at pharmacy of choice** o **PAR will be communicated to primary care provider as part of collaborative practice**

o Consult pharmacist, MD, NP if abnormal changes in mood (ie: thoughts of harm to self or others), new or worsening cardiovascular signs / symptoms

o General advice on smoking/tobacco cessation and side effects management, including possible need for dosage adjustments if taking medications metabolized by 1A2, 2E1 (such as clozapine or olanzapine) as a result of smoking cessation itself (ie: lose the enzyme induction effect from smoking)

Follow-up scheduled: o **in pharmacy or via telephone. Date:**

o If partial response only: assess adherence, adjust dose (except bupropion SR), tailor counseling to patient

Prescribing Pharmacist

Name:	Signature:
Pharmacy:	Telephone:
	Fax::
Email:	Date:
Primary Care Provider:	**Fax #:**

Pharmacist Minor Ailment Prescribing Record

To

This document is to inform you I met with your patient below who requested help with **tobacco cessation.**

After an assessment, a prescription was issued for

The prescription details and rationale for my decision are documented below. This is for your information to keep your records for this patient up to date.

Patient Demographics:		
Name:	HSN:	
Address:	DOB:	Gender: o male o female o other
Telephone:	□ Pregnant □ Breastfeeding	

Prescription Issued on _____

MEDICATION:

DIRECTIONS:

QUANTITY:

Rationale for prescription / relevant patient information:

I will follow-up with the patient on _____ and discuss these items:

o If partial response only: assess adherence, adjust dose (except bupropion SR), tailor counseling to patient

Prescribing Pharmacist:	
Name:	Signature:
Pharmacy:	Telephone:
Email:	Fax:

Primary Care Provider notified:	
Name:	Fax: