STEP 4: Practitioner Communication Letter

Dear:

Re (Patient name and address):

HSN: _____ **DOB:** _____

I have spoken to our patient about their smoking/tobacco status. They have chosen to:

- ☐ Not quit at this time
- ☐ Enroll in the *Partnership to Assist with Cessation of Tobacco* (PACT) program and receive cessation counseling services for up to a year with this pharmacy
- ☐ Commit to a quit date of: _____

Our patient has chosen:

- ☐ No cessation therapy/quit cold turkey
- ☐ Reduce to quit
- ☐ OTC nicotine replacement therapy with: _____
- ☐ Combination therapy with: _____
- ☐ To utilize prescription cessation therapy
  - Please Authorize as per patient request, below:
  - I have prescribed as per our collaborative practice agreement, below:

Prescription Drug Authorization for Tobacco Cessation

☐ 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 if seizure disorder/anorexia
Total Quantity: 165 (165 x 150mg tablets)

☐ 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)
*Dosage adjustment may be required in renal impairment
Total Quantity: 165 (11 x 0.5mg tablets and 154 x 1mg tablets)

☐ 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)
*For patients experiencing nausea
Total Quantity: 165 (165 x 0.5mg tablets)

Date: _____ **Signature:** _____

If you have any questions or concerns, I would be pleased to speak with you further about any of these issues.

Pharmacist name:

Pharmacy Contact Information: