Dear Doctor,

**Re: Prescription Request for Varenicline (Champix)**

**Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I am writing to inform you that I have seen the above named patient for their first consultation to stop nicotine use. After full discussion of the alternatives they have decided that they would like to use Varenicline (Champix) as the treatment option for their attempt.

As you will see from the table below I have completed a health questionnaire on your patient and confirmed that there are no contraindications. I have also discussed the treatment pros and cons. If you agree that Varenicline (Champix) is appropriate in this instance, I would be grateful if you would consider issuing him/her a prescription.

***(Practitioner - If yes is ticked for any box then the patient should not be prescribed Varenicline and referral to the GP is unnecessary. Offer other support options.)***

|  |  |  |
| --- | --- | --- |
| **Patient History** | **Yes** | **No** |
| Are you aged under 18? |  |  |
| Are you thinking of becoming pregnant, are pregnant or breastfeeding? |  |  |
| Are you taking any other medication to help you stop smoking? |  |  |
| Do you have severe renal impairment? |  |  |
| Have you ever had seizures (fits) or been told that you have epilepsy? |  |  |

All patients requesting Varenicline must agree to behavioural support alongside their prescription and I will, of course, update you on their progress.

***(Prescribing GP - The next prescription will be due in 1-2 weeks time and should only be provided on receipt of a follow up letter from me (Letter B). I would ask that you do not provide the patient with repeat prescriptions at this time.)***

|  |  |  |
| --- | --- | --- |
| **DAY**  | **DOSE** | **PRESCRIBE** |
| **1-3** | 0.5mg once daily | Starter pack (11 x 0.5mg and 14 x 1mg) |
| **4-7** | 0.5mg twice daily |
| **8-14** | 1mg twice daily |

If you have any queries or questions about this patient, please do not hesitate to contact me on telephone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Yours sincerely **PHARMACY STAMP**

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Stop Smoking Practitioner**

Dear Doctor,

**Re: Prescription Request for Varenicline (Champix)**

**Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_**

The above named patient has returned to see me in my capacity as a Stop Smoking Practitioner and continues to be motivated to stop smoking. They are currently using Varenicline (Champix) to support their quit attempt and are currently abstinent at the moment.

There have been no adverse events reported to date and I would therefore be most grateful if you could prescribe the maintenance pack requested below.

|  |  |  |  |
| --- | --- | --- | --- |
| **Day** | **Dose** | **Prescribe** | **Next Prescription Due (*Please tick*)** |
| **15-28** | 1mg twice daily | 1x maintenance pack (28 x1mg) |  |
| **29-56** | 1mg twice daily | 1x maintenance pack (56 x 1mg) |  |
| **57-84** | 1mg twice daily | 1x maintenance pack (56 x 1mg) |  |

I will continue to see your patient regularly for support to stop smoking and will keep you updated on their progress. Please do not issue any further prescription for this product except on receipt of a further letter from me (I would suggest you do not put this medicine on repeat prescription).

Many thanks for your support in this matter. Please do not hesitate to contact me if you have any further queries on telephone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Yours sincerely, **PHARMACY STAMP**

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Stop Smoking Practitioner**

Dear Doctor

**Re: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (*Pt Name*) ­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (*DoB*)**

The above named patient has been to see me with a view to stopping smoking. They have expressed a wish to use Nicotine Replacement Therapy (NRT) to help support their quit attempt. However, they are currently taking the medication indicated below and the Summary of Product Characteristics has highlighted the following drug interaction(s) with caution:

|  |  |  |  |
| --- | --- | --- | --- |
| **Tick** | **BNF Category/ Drug Name** | **Clinical relevance** | **Action to take** |
|  | **2.8.2 Warfarin** | **Moderate** | **INR may increase so monitor closely.** |
|  | **3.1.3 Theophylline** | **High** | **Monitor plasma levels weekly. Ask patient to seek help if develop signs of toxicity such as palpitations or nausea.** |
|  | **4.2.1 Chlorpromazine** | **Moderate** | **Be alert for increased adverse effects – dizziness, sedation, extra-pyramidal side effects.** |
|  | **4.2.1. Clozapine** | **High** | **Monitor serum drug levels before stopping and one/two weeks after.** |
|  | **4.2.1 Olanzapine** | **Moderate** | **Be alert for increased adverse effects – dizziness, sedation, and hypotension.** |
|  | **6.1.1 Insulin** | **Moderate** | **Insulin dose may need to be reduced. Ask patient to be alert for signs of hypoglycaemia and to test their blood glucose more frequently.** |

This letter is for your information, but where appropriate we have asked your patient to make an appointment to see you regarding this.

Yours sincerely

PRINT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Stop Smoking Practitioner**

**PHARMACY STAMP**

Dear Doctor

**Re: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (*Pt Name*) ­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (*DoB*)**

The above named patient has been to see me with a view to stopping smoking. They have expressed a wish to use Nicotine Replacement Therapy (NRT) to help support their quit attempt. However, they currently have a medical condition (­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_), which requires their GP to assess and indicate whether or not treatment with NRT can proceed.

The following medical conditions have been highlighted as requiring a referral to the patients GP for assessment and clearance to begin treatment with NRT:

* **Phaeochromocytoma**.
* **Severe cardiovascular disease** where patient has experienced a cardiovascular event or hospitalisation for a cardiovascular complaint in the previous 2 weeks e.g. strokes, TIA, myocardial infarction, cardiac arrhythmia, coronary artery bypass graft and angioplasty.
* **Unstable angina**, i.e. chest pain on minimal exertion within the last 2 weeks.
* **Severe peripheral vascular disease**.
* **Active peptic ulceration**.

Please indicate the result of your assessment below as to whether the patient can/cannot begin NRT treatment to support their stop smoking quit attempt.

***Please tick here***

|  |  |
| --- | --- |
| The above named patient **CAN** begin NRT treatment to support a stop smoking attempt |  |
| The above named patient **CANNOT** begin NRT treatment to support a stop smoking attempt |  |

***DOCTOR - PLEASE FAX THIS SHEET TO ME ON THE FOLLOWING NUMBER:***

***Tel Fax No:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

Yours sincerely

PRINT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: ­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Stop Smoking Practitioner PHARMACY STAMP**

Dear Doctor,

**Re: Patient Stop Smoking Support Outcome**

**Name**

**Address**

**DOB**

The patient above attended the Stop Smoking Service recently and received support and pharmacotherapy for their quit attempt.

The outcome at the 4-6 week follow-up (the current indicator for successful treatment outcome) was as follows: -

|  |  |
| --- | --- |
| Patient recorded as a validated quit (successful non-smoker) |  |
| Patient recorded as a continuing smoker |  |
| Patient recorded as Lost to Follow-up (smoking status unknown) |  |

Please do not hesitate to contact me if you have any further queries on telephone number:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yours sincerely,

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Stop Smoking Practitioner**

 PHARMACY STAMP