

PREVENTIVE CARE

TOBACCO CESSATION – NRT (Nicotine Replacement Therapy) and Non-NRT

STATEWIDE DRUG THERAPY MANAGEMENT PROTOCOL for the OREGON PHARMACIST

AUTHORITY and PURPOSE: Per ORS 689.645, a pharmacist may provide patient care services pursuant to a statewide drug therapy management protocol.

- Following all elements outlined in OAR 855-020-0110, a pharmacist licensed and located in Oregon may prescribe individual or multiple Nicotine Replacement Therapy (NRT) OTC and Rx for tobacco cessation.
- Following all elements outlined in OAR 855-020-0110, a pharmacist licensed and located in Oregon may prescribe non-NRT medications for tobacco cessation.

STANDARDIZED PATIENT ASSESSMENT PROCESS ELEMENTS:

- Utilize the standardized Tobacco Cessation Patient Intake Form (pg. 2-4)
- Utilize the standardized Tobacco Cessation Assessment and Treatment Care Pathway (pg. 5-6)

PHARMACIST TRAINING/EDUCATION:

- Minimum 2 hours of documented ACPE CE related to pharmacist prescribing of tobacco cessation products

Oregon Board of Pharmacy

Approved: 8/2020
Reviewed:
Modified:

Tobacco Cessation Self-Screening Patient Intake Form

Name _____ Date of Birth _____ Age _____ Today's Date _____
 Today's BP _____ / _____ mmHg (*must be taken by a RPH)
 Do you have health insurance? **Yes / No** Name of insurance provider _____
 PCP/Health Care Provider's Name _____
 List of medicine you take _____

Any allergies to medicines? **Yes / No** If yes, list them here _____
 Any food allergies (ex. menthol/soy) _____

Do you have a preferred tobacco cessation product you would like to use? _____

Have you tried quitting smoking in the past? If so, please describe _____
 What best describes how you have tried to stop smoking in the past?

- ☐ "Cold turkey"
- ☐ Tapering or slowly reducing the number of cigarettes you smoke a day
- ☐ Medicine
- ☐ Nicotine replacement (like patches, gum, inhalers, lozenges, etc.)
 - ☐ Prescription medications (ex. bupropion [Zyban®, Wellbutrin®], varenicline [Chantix®])
- ☐ Other _____

Health and History Screen - Background Information:

1.	Are you under 18 years old?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Are you pregnant, nursing, or planning on getting pregnant or nursing in the next 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
3.	Are you currently using and trying to quit non-cigarette products (ex. Chewing tobacco, vaping, e-cigarettes, Juul)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Medical History:

4.	Have you ever had a heart attack, irregular heart beat or angina, or chest pains in the past two weeks?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
5.	Do you have stomach ulcers?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
6.	Do you wear dentures or have TMJ (temporomandibular joint disease)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
7.	Do you have a chronic nasal disorder (ex. nasal polyps, sinusitis, rhinitis)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
8.	Do you have asthma or another chronic lung disorder (ex. COPD, emphysema, chronic bronchitis)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure

Tobacco History:

9.	Do you smoke fewer than 10 cigarettes a day?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Stop here if patient and pharmacist are considering nicotine replacement therapy.

KEEP GOING



If patient and pharmacist are considering non-nicotine replacement therapy (ex. varenicline or bupropion) continue to answer the questions below.

Medical History Continued:

10.	Have you ever had an eating disorder such as anorexia or bulimia?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
11.	Have you ever had a seizure, convulsion, significant head trauma, brain surgery, history of stroke, or a diagnosis of epilepsy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
12.	Have you ever been diagnosed with chronic kidney disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
13.	Have you ever been diagnosed with liver disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
14.	Have you been diagnosed with or treated for a mental health illness in the past 2 years? (ex. depression, anxiety, bipolar disorder, schizophrenia)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure

Medication History:

15.	Do you take a monoamine oxidase inhibitor (MAOI) antidepressant? (ex. selegiline [Emsam [®] , Zelapar [®]], Phenelzine [Nardil [®]], Isocarboxazid [Marplan [®]], Tranylcypromine [Parnate [®]], Rasagiline [Azilect [®]])	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
16.	Do you take linezolid (Zyvox [®])?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
17.	Do you use alcohol or have you recently stopped taking sedatives? (ex. Benzodiazepines)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure

The Patient Health Questionnaire 2 (PHQ 2):

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not At All	Several Days	More Than Half the Days	Nearly Every Day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3

Suicide Screening:

Over the last 2 weeks, how often have you had thoughts that you would be better off dead, or have you hurt yourself or had thoughts of hurting yourself in some way?	0	1	2	3
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Patient Signature _____ Date _____

Optional-May be used by pharmacy if desired

Patient Name:	Date of birth:
Address:	
City/State/Zip Code:	Phone number:

- ☐ Verified DOB with valid photo ID
- ☐ Referred patient to Oregon Quit Line (1-800-QUIT-NOW or www.quitnow.net/oregon or fax: 800-483-3114)
- ☐ BP Reading: ____/____ *must be taken by a RPh

Note: RPh must refer patient if blood pressure \geq 160/100

Rx

Written Date: _____

Prescriber Name: _____ Prescriber Signature: _____

Pharmacy Address: _____ Pharmacy Phone: _____

-or-

☐ Patient Referred
(fax or electronic
notification to the Quit
Line is acceptable)

Notes: _____

Tobacco Cessation Assessment & Treatment Care Pathway

1) Health and History Screen Part 1 Review Tobacco Cessation Patient Questionnaire (Questions 1 -2)	No = No Contraindicating Conditions. Continue to step 2	Yes/Not sure = Contraindicating Conditions. Refer	Refer to PCP AND Oregon Quit Line 1-800-QUIT-NOW
2) Health and History Screen Part 2 Review Tobacco Cessation Patient Questionnaire (Question 3)	Smoking Cigarettes. Continue to step 3	Yes to question 3 Refer	Refer to Oregon Quit Line 1-800-QUIT-NOW to receive counseling and NRT
3) Blood Pressure Screen Take and document patient’s current blood pressure. (Note: RPH may choose to take a second reading if initial is high)	BP < 160/100. Continue to step 4	BP ≥ 160/100 Refer	Refer to PCP AND Oregon Quit Line 1-800-QUIT-NOW
4) Medical History Nicotine Replacement Therapy Questions (Questions 4-5)	No, to question 4 and 5. Continue to step 5	Yes, to question 4 and/or 5 Refer	Refer to PCP AND Oregon Quit Line 1-800-QUIT-NOW
5) Medical History Nicotine Replacement Therapy Questions (Questions 6-8) Question 6 = if Yes, avoid using nicotine gum Question 7 = if Yes, avoid using nicotine nasal spray Question 8 = if Yes, avoid using nicotine inhaler			
Prescribing NRT*(pg.6): <ul style="list-style-type: none">Combination NRT is preferred (Nicotine patch + Acute NRT)Acute NRT = Nicotine gum, Nicotine lozenge, Nicotine nasal spray, Nicotine inhaler		Tobacco History (Question 9 on questionnaire) If Yes to smoking <=10 cigs/day, start with nicotine patch 14mg/day If No to smoking > 10 cigs/day start with nicotine patch 21mg/day	
6) Medical History Bupropion and varenicline screening Questions 10-14	Consider NRT* if yes to any question from 10-14		
	a) If yes to any question → avoid bupropion. If patient still wants bupropion, refer. Refer		Refer to PCP AND Oregon Quit Line 1-800-QUIT-NOW
	b) If yes to any questions from 12-14→ avoid varenicline. If patient still wants varenicline, refer. Refer		
	If patient answered no to questions 10 – 14, continue to step 7. If patient answered no to questions 12-14, but yes to question 10 and/or 11, AND wants varenicline (but not bupropion), skip to step 8		
7) Medication History Questions 15-17 on questionnaire.	If patient answered no to questions 15-17, review depression screening step 8.	If patient answered yes to any question from 15-17 → Avoid bupropion. - Refer if patient still wants bupropion. - If patient wants varenicline, continue to depression screening step 8. Refer	Refer to PCP if patient wants bupropion; NRT* can be considered
8) The Patient Health Questionnaire 2 (PHQ 2): Depression Screening	Score < 3 on PHQ2. Review Suicide Screening in step 9.	Score ≥ 3 on PHQ. Avoid bupropion and varenicline, refer to PCP for treatment. NRT* can be offered. Refer	Refer to PCP; NRT* can be considered
9) Suicide Screening	Score of 0 on suicide screening. May prescribe bupropion or varenicline.	Score ≥ 1 on suicide screening. Immediate referral to PCP. Refer	Call PCP office to notify them of positive suicide screening and determine next steps. After hours, refer to suicide hotline 1-800-273-8255

Prescribing Bupropion: 150mg SR daily for 3 days then 150mg SR twice daily for 8 weeks or longer. Quit day after day 7. Consider combining with Nicotine patch or Nicotine lozenge or Nicotine gum for increased efficacy.* For patients who do not tolerate titration to the full dose, consider continuing 150mg once daily as the lower dose has shown efficacy.	Prescribing Varenicline: 0.5mg daily for 3 days then 0.5mg twice daily for 3 days then 1mg twice daily for 12 to 24 weeks (may use Starter Pack). Quit day after day 7 or alternatively quit date up to 35 days after initiation of varenicline. Generally not use in combination with other smoking cessation medications.
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*Nicotine Replacement Dosing:

	Dose
Long Acting NRT	
Nicotine Patches	<ul style="list-style-type: none"> • Patients smoking >10 cigarettes/day: begin with 21mg/day for 6 weeks, followed by 14mg/day for 2 weeks, finish with 7mg/day for 2 weeks • Patients smoking ≤ 10 cigarettes/day: begin with 14mg/day for 6 weeks, followed by 7mg/day for 2 weeks • Note: Adjustment may be required during initial treatment (move to higher dose if experiencing withdrawal symptoms; lower dose if side effects are experienced).
Acute NRT	
Nicotine Gum	<ul style="list-style-type: none"> • Chew 1 piece of gum when urge to smoke occurs. If strong or frequent cravings are present after 1 piece of gum, may use a second piece within the hour (do not continuously use one piece after the other). • Patients who smoke their first cigarette within 30 minutes of waking should use the 4 mg strength; otherwise the 2 mg strength is recommended. • Use according to the following 12-week dosing schedule: <ul style="list-style-type: none"> ○ Weeks 1 to 6: Chew 1 piece of gum every 1 to 2 hours (maximum: 24 pieces/day); if using nicotine gum alone without nicotine patches, to increase chances of quitting, chew at least 9 pieces/day during the first 6 weeks ○ Weeks 7 to 9: Chew 1 piece of gum every 2 to 4 hours (maximum: 24 pieces/day) ○ Weeks 10 to 12: Chew 1 piece of gum every 4 to 8 hours (maximum: 24 pieces/day)
Nicotine Lozenges	<ul style="list-style-type: none"> • 1 lozenge when urge to smoke occurs; do not use more than 1 lozenge at a time • Patients who smoke their first cigarette within 30 minutes of waking should use the 4 mg strength; otherwise the 2 mg strength is recommended. • Use according to the following 12-week dosing schedule: <ul style="list-style-type: none"> ○ Weeks 1 to 6: 1 lozenge every 1 to 2 hours (maximum: 5 lozenges every 6 hours; 20 lozenges/day); if using nicotine lozenges alone without nicotine patches, to increase chances of quitting, use at least 9 lozenges/day during the first 6 weeks ○ Weeks 7 to 9: 1 lozenge every 2 to 4 hours (maximum: 5 lozenges every 6 hours; 20 lozenges/day) ○ Weeks 10 to 12: 1 lozenge every 4 to 8 hours (maximum: 5 lozenges every 6 hours; 20 lozenges/day)
Nicotine Inhaler	<ul style="list-style-type: none"> • <i>Initial treatment:</i> 6 to 16 cartridges/day for up to 12 weeks; maximum: 16 cartridges/day • Use beyond 6 months is not recommended (has not been studied). If patient is unable to stop smoking by the fourth week of therapy, consider discontinuation. • <i>Discontinuation of therapy:</i> After initial treatment, gradually reduce daily dose over 6 to 12 weeks. Some patients may not require gradual reduction of dosage and may stop treatment abruptly.
Nicotine Nasal Spray	<ul style="list-style-type: none"> • Initial: 1 to 2 doses/hour (each dose [2 sprays, one in each nostril] contains 1 mg of nicotine) • Adjust dose as needed based on patient response; do not exceed more than 5 doses (10 sprays) per hour [maximum: 40 mg/day (80 sprays)] or 3 months of treatment • If using nicotine nasal spray alone without nicotine patches, for best results, use at least the recommended minimum of 8 doses per day (less is likely to be effective). • Use beyond 6 months is not recommended (has not been studied). If patient is unable to stop smoking by the fourth week of therapy, consider discontinuation. • <i>Discontinuation of therapy:</i> Discontinue over 4 to 6 weeks. Some patients may not require gradual reduction of dosage and may stop treatment abruptly.

Oregon licensed pharmacist must adhere to Prescribing Parameters, when issuing any prescription for tobacco cessation.

PRESCRIBING PARAMETERS:

- 1st prescription up to 30 days
- Maximum duration = 12 weeks
- Maximum frequency = 2x in rolling 12 months

TREATMENT CARE PLAN:

- Documented follow-up: within 7-21 days, phone consultation permitted