

QUITWORKSSM

EIPP

Tobacco Treatment Enrollment

A Collaboration of the Mass. Department of Public Health & Mass. Health Plans

Tobacco Treatment Checklist

ASK about smoking. Screen using the 5 P's.

Parents Peers Partner Past use (before pregnancy) Use during pregnancy

ASSESS. Has client smoked in the past 3 months? If yes, is she ready to make a quit attempt? Is she interested in telephone counseling?

Ready to quit Thinking about quitting Not ready to quit

ADVISE to quit. Recommend quitting. **Advise to discuss any medications with medical provider.**

Nicotine Replacement: patch gum lozenge inhaler nasal spray

Other: Bupropion (Zyban®/Wellbutrin SR®) Varenicline (Chantix®)

REFER to QuitWorks. Fill out and fax this form to the Try-To-STOP TOBACCO Resource Center at **1-866-560-9113**.

MONITOR. Follow up on use and provide support.

Try-To-STOP TOBACCO RESOURCE CENTER OF MASSACHUSETTS

Massachusetts Resident Enrollment Form

Fax this part of form to **1-866-560-9113**.

REFERRAL SOURCE/FOLLOW-UP CONTACT			
referred by name _____	facility _____		phone (area code + number) _____
address _____			fax (area code + number) _____
follow-up report contact _____	phone (area code + number) _____	fax (area code + number) _____	
PATIENT			
first name _____	last name _____	date of birth (month/day/year) _____	
phone (area code + number) () _____	May we leave a message? <input type="checkbox"/> yes <input type="checkbox"/> no	language preference (check): <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> other (specify) _____	
email address _____			
client address _____	city _____	state _____	zip _____
PRIMARY INSURANCE – check one			
MASS HEALTH/MEDICAID Check one:	<input type="checkbox"/> PCC Plan	<input type="checkbox"/> BMC Health Net	<input type="checkbox"/> Fallon
	<input type="checkbox"/> Neighborhood Health Plan	<input type="checkbox"/> Network Health	<input type="checkbox"/> Fee for Service
MEDICARE SUPPLEMENTAL PLAN	<input type="checkbox"/> Blue Cross Blue Shield MA	<input type="checkbox"/> Harvard Pilgrim	<input type="checkbox"/> Tufts Health Plan
	<input type="checkbox"/> Fallon		
COMMERCIAL INSURANCE Check one:	<input type="checkbox"/> Blue Cross Blue Shield MA	<input type="checkbox"/> Harvard Pilgrim	<input type="checkbox"/> Tufts Health Plan
	<input type="checkbox"/> Neighborhood Health Plan		
UNINSURED <input type="checkbox"/>	<input type="checkbox"/> Fallon	<input type="checkbox"/> Other _____	
THE RESOURCE CENTER USUALLY CALLS THE CLIENT WITHIN 3 BUSINESS DAYS OF RECEIVING A REFERRAL. WHEN SHOULD WE CALL?			
check all that apply:	<input type="checkbox"/> morning	<input type="checkbox"/> afternoon	<input type="checkbox"/> evening
	<input type="checkbox"/> no preference		

I, _____, hereby authorize Try-To-STOP TOBACCO Resource Center of Massachusetts, (the "Resource Center"), and its representatives to disclose information about me to:

- 1) the American Cancer Society Quitline to the extent necessary to allow me to participate in its tobacco cessation counseling program; and
- 2) my primary care provider or other provider ("Provider") I designate to the Resource Center to the extent the Resource Center deems necessary to give my Provider an update of my progress in attempting to stop smoking.

I authorize my Provider to release the information on this enrollment form to the Resource Center for purposes of my participation in the QuitWorks program. I also authorize the Resource Center and its representatives to contact me upon receiving this referral from my Provider.

SIGNATURE OF QUITWORKS CLIENT OR CLIENT'S REPRESENTATIVE _____

DATE _____

PRINTED NAME OF QUITWORKS CLIENT REPRESENTATIVE _____

RELATIONSHIP TO CLIENT _____

Quick Guide To Pharmacotherapy In Tobacco Treatment

NICOTINE REPLACEMENT OPTIONS

PATCHES

Nicotrol [®] 15 mg	Initial: MAX:	1 patch/16 hrs. Same as above	Treatment Duration: 8 wks.
* Nicoderm [®] CQ 7 mg, 14 mg, 21 mg	Initial: MAX:	1 patch/24 hrs. Same as above	Treatment Duration: 8 wks.

*GUM

Nicorette [®] 2 mg, 4 mg	Initial: MAX:	1 piece every 1–2 hrs. 24 pieces/24 hrs.	Treatment Duration: 8–12 wks.
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LOZENGE

Commit [®] 2 mg 4 mg		1 lozenge/1–2 hrs. (wks 1–6) 1 lozenge/2–4 hrs. (wks 7–9) 1 lozenge/4–8 hrs. (wks 10–12)	Treatment Duration: 12 wks.
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NASAL SPRAY

Nicotrol [®] NS 10 mg/ml	Initial: MAX:	1–2 doses/hr. 5 doses/hr. or 40 doses/day	Treatment Duration: 3–6 mos.
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INHALER

Nicotrol [®] Inhaler 10 mg/cartridge	Initial: MAX:	6–16 cartridges/day 16 cartridges/day	Treatment Duration: 3–6 mos.
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NON-NICOTINE MEDICATION

BUPROPION HCL SR

* Wellbutrin SR 150 mg tablets	Initial: MAX:	150 mg/day (days 1–3) 300 mg/day (day 4+) 300 mg/day	Treatment Duration: 7–12 wks.
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VARENICLINE

Chantix [®]	Initial: MAX:	0.5 mg/day (days 1–3) 0.5 mg/2x/day (days 4–7) 1.0 mg/2x/day (day 8+) 2 mg/day	Treatment Duration: Up to 12 weeks
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Inclusion of this adult dosage chart is strictly for the convenience of the prescribing provider. Please consult the Physicians' Desk Reference for complete product information and contraindications. This chart does not indicate or authorize insurance benefit coverage for any of these medications. For insurance benefit information, the patient will need to contact his/her insurer directly. The cost or provision of these medications is not included as any part of the Try-To-STOP TOBACCO Resource Center of Massachusetts or QuitWorks program.

Make smoking history.