DEVON
 PHARMACY STOP SMOKING SERVICE

Medication Request Letter- Varenicline (Champix®**)**

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**Dear** *(Name of GP):* **Date of request:**

**Client name**: **Date of birth:**

**Client address**:

I have discussed smoking cessation treatments with this patient at our clinic today. I confirm that this patient will be receiving support from myself and would therefore be grateful if you would consider prescribing the product indicated below. I have advised the client that he/she may have to have an initial appointment with their surgery in order to receive the prescription and may need a clinical assessment. I have informed the patient they may incur up to four prescription charges. I will send a letter of outcome to you when the patient is assessed 28 days after their quit date.

**A full treatment course should be considered following the local Joint Formulary. PLEASE NOTE VARENICLINE IS NOW A FIRST LINE TREATMENT OPTION. The following prescribing schedule is recommended. See local Joint Formulary for further details. Prescriptions should be issued in four stages, 2 weeks, 2 weeks, 4 weeks and 4 weeks. For more details on Varenicline please see Summary of Product Characteristics.**

## PRESCRIPTION 2

## PRESCRIPTION 3

## PRESCRIPTION 4

## PRESCRIPTION 1

**4 Weeks (Maintenance Pack) 56 tabs**

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**2 Weeks (Maintenance Pack) 28 tabs**

**2 Weeks (Initiation Pack) 25 tabs**

**1mg TWICE DAILY**

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**DAYS 1–3: 0.5mg ONCE DAILY**

**DAYS 4-7: 0.5mg TWICE DAILY**

**DAYS 8-14: 1mg TWICE DAILY**

**Planned Quit Date: Fagerström Score: CO Reading:**

**Additional information**

**If you have any queries about this patient, please do not hesitate to contact me on:**

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**Stop Smoking Adviser: …………………………………………………………………………………………………………..**

**Pharmacy branch: …………………………………………………………………………………………………………………**