

DEVON
PHARMACY STOP SMOKING SERVICE

Medication Request Letter- Bupropion (Zyban**)**

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

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

**Client address**:

**Postcode**:

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. The following prescribing schedule is recommended. See local Joint Formulary for further details. Medication should be issued in four stages, 2 weeks, 2 weeks, 2 weeks, and 3 weeks. For more details on Bupropion please see Bupropion Summary of Product Characteristics.**

## PRESCRIPTION 1

## PRESCRIPTION 4

## PRESCRIPTION 2

## PRESCRIPTION 3

**3 weeks**

**42 tablets**

**2 weeks**

**28 tablets**

**2 Weeks**

**28 tablets**

**2 Weeks**

**22 tablets**

150mg once daily (6 days) 150mg twice daily 150mg twice daily 150mg twice daily

150mg twice daily (8 days)

**Planned Quit Date: Fagerstrom 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: …………………………………………………………………………………………………………………**