



A Service of the Try-To-Stop Smokers' Helpline

In Collaboration with the Massachusetts Department of Public Health and Massachusetts Health Plans



Holyoke Medical Center

A Member of Valley Health Systems

575 Beech Street  
Holyoke, MA 01040

Patient Stamp, Label or Info (Name, Record Number/DOB, Date)

- If a patient is interested in quitting smoking, fill out this form with them.
- Fax completed form to 1-866-560-9113.
- The Try-To-Stop Smokers' Quitline will contact the patient, offer free cessation services and send feedback reports to the provider listed below.
- This program is free for all Massachusetts residents regardless of insurance status

## Massachusetts Enrollment Form

Tobacco users can also call 1-800-Try-To-Stop (1-800-879-8678) to receive services

### Patients: Complete this section

First Name _____		Last Name _____		Are you 18 or older? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Mailing Address _____ ( )			City _____	State _____	Zip _____
Phone Number _____					
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					
Language Preference: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other (specify) _____					
May we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Primary Insurance of Tobacco User: <input type="checkbox"/> Blue Cross Blue Shield MA <input type="checkbox"/> Tufts Health Plan <input type="checkbox"/> Harvard Pilgrim <input type="checkbox"/> MassHealth/Medicaid <input type="checkbox"/> Other <input type="checkbox"/> None					
I authorize this provider to release the information on this enrollment form to QuitWorks so that I may be contacted and participate in the QuitWorks program. I also authorize QuitWorks to disclose information about my progress in attempting to quit smoking to the health care provider listed on this form.					
Patient Signature _____				Date _____	

### Health Care Providers: Complete this section

Referring Provider: _____	Phone Number _____ ( )
Facility: _____	Fax Number _____ ( )
Address: _____	
Send feedback report to:	
<input type="checkbox"/> Same as above or _____	( ) ( )
Name _____	Phone Number _____ Fax Number _____
PEDIATRICS ONLY:	
Patient's relationship to child: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other (specify) _____	
Child/Children's name: (to help with recordkeeping) _____	

Copies of this form can be downloaded from WWW.QUITWORKS.ORG

**Fax this form toll-free to 1-866-560-9113**

### NICOTINE REPLACEMENT OPTIONS

#### PATCHES

Nicoderm <sup>®</sup> CQ 7 mg, 14 mg, 21 mg	Initial: 1 patch/24 hrs. MAX: Same as above	Treatment Duration: 8 wks.
--	--	----------------------------

#### GUM

Nicorette <sup>®</sup> 2 mg, 4 mg	Initial: 1 piece every 1–2 hrs. MAX: 24 pieces/24 hrs.	Treatment Duration: 8–12
--------------------------------------	---	--------------------------

#### LOZENGE

Commit <sup>®</sup> 2 mg, 4 mg	Initial 1 lozenge/1–2 hrs. (wks 1–6) 1 lozenge/2–4 hrs. (wks 7–9) 1 lozenge/4–8 hrs. (wks 10–12) MAX: 20 pieces/24 hrs.	Treatment Duration: 12 wks.
-----------------------------------	---	-----------------------------

#### NASAL SPRAY

Nicotrol <sup>®</sup> NS 10 mg/ml	Initial: 1–2 doses/hr. MAX: 5 doses/hr. or 40 doses/day	Treatment Duration: 3–6 mos.
--------------------------------------	--	------------------------------

#### INHALER

Nicotrol <sup>®</sup> Inhaler 10 mg/cartridge	Initial: 6–16 cartridges/day MAX: 16 cartridges/day	Treatment Duration: 3–6 mos.
--	--	------------------------------

### NON-NICOTINE MEDICATION

#### BUPROPION HCL SR

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

#### VARENICLINE

Chantix <sup>®</sup>	Initial: 0.5 mg/day (days 1–3) 0.5 mg/2x/day (days 4–7) 1.0 mg/2x/day (day 8+) MAX: 2 mg/day	Treatment Duration: Up to 12 wks.
----------------------	---	-----------------------------------

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.**