QUITWORKS℠

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

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

WHN | MHP Site Code: ☐ ☐ ☐

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

Massachusetts Enrollment Form

1. **ASSESS** readiness to quit: "What are your thoughts about quitting at this time?"
   ❑ **Ready** ❑ **Thinking About Quitting** ❑ **Not Ready to Quit**

2. **REFER** to QuitWorks "Are you interested in receiving free and confidential quit smoking assistance over the phone? You may be eligible for free nicotine patches." ❑ **Yes** ❑ **No** ❑ **Not Sure**

   If YES, fill out the QuitWorks enrollment form, fax to **(617) 624-5505**,
   And be sure to tell the client that a QuitWorks specialist will call in 3-5 days.

Patients: Complete this section

First Name ______ **Last Name** ______ **Are you 18 or older?** ❑ **Yes** ❑ **No**

Mailing Address ______ **City** ______ **State** ______ **Zip** ______

( ) ______
Phone Number

When should we call? (check all that apply) ❑ **Morning** ❑ **Afternoon** ❑ **Evening** ❑ **No preference**

Language Preference: ❑ **English** ❑ **Spanish** ❑ **Other (specify)** ______

May we leave a message? ❑ **Yes** ❑ **No**

Insurance Status: ❑ **Uninsured** ❑ **Underinsured** ❑ **Other**

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:

❑ **Same as above** **or** ______ **Name** ( ) ______ **Phone Number** ( ) ______ **Fax Number**

PEDIATRICS ONLY:

Patient's relationship to child: ❑ **Mother** ❑ **Father** ❑ **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 1-617-624-5505

Effective 6/30/2009

QUITWORKS℠

Quick Guide To Pharmacotherapy In Tobacco Treatment

NICOTINE REPLACEMENT OPTIONS

PATCHES

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

GUM

Product		Dosage	Duration
Nicorette® 2 mg, 4 mg	Initial: MAX:	1 piece every 1–2 hrs. 24 pieces/24 hrs.	Treatment Duration: 8–12

LOZENGE

Product		Dosage	Duration
Commit® 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)	Treatment Duration: 12 wks.
	MAX:	20 pieces/24 hrs.	

NASAL SPRAY

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

INHALER

Product		Dosage	Duration
Nicotrol® Inhaler 10 mg/cartridge	Initial: MAX:	6–16 cartridges/day 16 cartridges/day	Treatment Duration: 3–6 mos.

NON-NICOTINE MEDICATION

BUPROPION HCL SR

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

VARENICLINE

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

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.