

# Tobacco Cessation Guideline

These clinical guidelines are designed to assist clinicians by providing an analytical framework for the evaluation and treatment of patients. They are not intended to replace a clinician’s judgment or to establish a protocol for all patients with a particular condition. A guideline will rarely establish the only approach to a problem.

## GUIDELINE HISTORY and APPROVAL

ACTION	SEED GUIDELINE and/or MAIN INFORMATION & GROUP SOURCE(S)	DATE	ORGANIZATION
Guideline reviewed and approved	Treating Tobacco Use and Dependence Clinical Practice Guideline. U.S. Department of Health and Human Services. June 2000 Website located at: <a href="http://www.surgeongeneral.gov/tobacco/">www.surgeongeneral.gov/tobacco/</a>	Sept. 13, 2004	Geisinger Health Plan/ Tobacco Cessation Clinical Guideline Team
Guideline reviewed and approved	Same as above	Sept. 30, 2004	Geisinger Health Plan Medical Directors
Guideline reviewed and approved	Same as above	Oct. 7, 2004	Geisinger Health Plan/Clinical Guideline Committee
Guideline reviewed and approved	Same as above	Sept. 15, 2004	Geisinger Health Plan Pharmacy
Guideline reviewed and approved	Same as above	Jan. 17, 2005	Geisinger Health Plan/ Medical Management Committee
Guideline reviewed and approved	Same as above	June 22, 2005	Geisinger Health Plan/ Medical Management Administrative Committee
Guideline reviewed and approved	Same as above	July 27, 2005	Geisinger Health Plan/ Quality Improvement Committee
Guideline reviewed and approved	Same as above	Jan. 15, 2007	Geisinger Health Plan/Clinical Guideline Committee
Guideline Reviewed	Same as above.	Feb 7 - Mar. 8, 2007	Geisinger Health Plan Pharmacy Dept
Guideline Reviewed	Same as above.	May 23 – Jun 4, 2007	Geisinger Health Plan Medical Directors
Guideline Reviewed	Same as above.	July 2, 2007	Geisinger Health Plan/ Medical Management Committee
Guideline Reviewed	Same as above.	July 25, 2007	Geisinger Health Plan/ Quality Improvement Committee

Guideline reviewed and approved	Treating Tobacco Use and Dependence Clinical Practice Guideline. U.S. Department of Health and Human Services .May 2008 Website located at: <a href="http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat2.chapter.28163">http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat2.chapter.28163</a>	Oct 2008-	Geisinger Health Plan/Clinical Guideline Committee
Guideline Reviewed	Same as above	Nov 17-24, 2008	Geisinger Health Plan Pharmacy Dept
Guideline Reviewed	Same as above	June 15, 2009	Geisinger Health Plan/ Medical Management Committee
Guideline Reviewed	Same as above	June 8-19, 2009	Geisinger Health Plan Medical Directors
Guideline Reviewed	Same as above	July 22, 2009	Geisinger Health Plan/ Quality Improvement Committee
Guideline Reviewed	Same as above	June 10, 2011	Geisinger Health Plan/Clinical Guideline Committee
Guideline Approved	Same as above	July 27, 2011	Geisinger Health Plan/ Quality Improvement Committee

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## **OVERVIEW**

Tobacco use has been cited as the chief avoidable cause of illness and death in our society, responsible for more than 430,000 deaths in the United States each year. Smoking is a known cause of cancer, heart disease, stroke, complications of pregnancy, and chronic obstructive pulmonary disease.

Tobacco use includes cigarettes, cigars, pipe, and smokeless tobacco products such as chewing tobacco and snuff.

Twenty-five percent of adult Americans smoke. Smoking prevalence among adolescents has risen dramatically since 1990, with more than 3,000 additional children and adolescents becoming regular users of tobacco each day.

Smoking-attributable health care expenditures are estimated at \$96 billion per year in direct medical expenses and \$97 billion in lost productivity.

Clinicians do not assess and treat tobacco use consistently and effectively. In 1995, smoking status was identified in 67 percent of clinic visits, smoking cessation counseling was provided in only 21 percent of smokers' clinic visits, and treatment is typically offered to patients suffering from tobacco-related diseases.

Smoking cessation interventions delivered in a timely and effective manner, significantly reduce the smoker's risk of suffering from smoking related disease.

## **REFERENCES**

U.S. Department of Health and Human Services. *The Health Consequences of Smoking – A Report of the Surgeon General, 2004.*

Centers for Disease Control and Prevention. Public health focus: effectiveness of smoking-control strategies—United States. *MMWR* 1992;41:645–7, 653

JM McGinnis and WH Foege. Actual causes of death in the United States *JAMA* 1993. 270: 2207-12.

Heatherton TF, Kozlowski LT, Frecker RC, Fagerstrom KO. The Fagerstrom Test for Nicotine Dependence: A revision of the Fagerstrom Tolerance Questionnaire. *British Journal of Addictions* 1991;86:1119-27

## **SEED GUIDELINE(S)**

Treating Tobacco Use and Dependence Clinical Practice Guideline. U.S. Department of Health and Human Services. May 2008

## **GOALS**

1. Incorporation of the Tobacco Cessation Guideline in the risk management of tobacco abuse.
2. Assist patients and clinicians in the management of tobacco abuse and successful cessation.
3. The promotion of pulmonary function tests (PFT's) for all current smokers  $\geq$  age 40.

### FAST FACTS

Tobacco dependence is a chronic disease that often requires repeated intervention and multiple attempts to quit. Effective treatments exist, however, that can significantly increase rates of long-term abstinence.

It is important that every health care provider ask patients if they use tobacco (cigarettes, cigars, pipe, chew, snuff), advise them to quit, and educate them about available pharmacotherapy and behavioral strategies.

Effective tobacco dependence treatments are available; every patient who after consultation, expresses a desire to quit should be offered at least one of these treatments:

- Patients willing to try to quit tobacco use should be provided with treatments identified as effective in the guideline or referred to the Geisinger Health Plan Tobacco Cessation Program at 1-800-883-6355.

Patients unwilling to try to quit tobacco use should be provided with a brief intervention designed to increase their motivation to quit.

There is strong dose-response relation between the intensity of tobacco cessation counseling and its effectiveness. Treatments involving person-to-person contact (individual, group or telephone) are consistently effective, and their effectiveness increases with treatment intensity (e.g., minutes of contact).

Numerous effective pharmacotherapies for tobacco cessation exist and may be considered with patients attempting to quit, except when medically contraindicated or with specific populations for which there is insufficient evidence of effectiveness (i.e., pregnant women, smokeless tobacco users, light smokers, and adolescents):

Counseling and medication are effective when used by themselves for treating tobacco dependence. The combination of counseling and medication, however, is more effective than either alone. Thus, clinicians should encourage all individuals making a quit attempt to use both counseling and medication.

If a tobacco user currently is unwilling to make a quit attempt, clinicians should use the motivational treatments shown in this Guideline to be effective in increasing future quit attempts.

**Note: Pharmaceutical coverage is dependent upon individual pharmacy benefit design and certain drugs may require prior authorization. Providers are encouraged to review the GHP formulary at <http://www.thehealthplan.com>, or contact the GHP Pharmacy Department at 1-800-988-4861.**

First line pharmacotherapies were identified that reliably increase long-term smoking abstinence rates:

- Bupropion SR - Rx
- Nicotine gum – OTC
- Nicotine lozenge
- Nicotine inhaler –Rx
- Nicotine nasal spray –Rx
- Nicotine patch – OTC
- Chantix - Rx

Two second-line pharmacotherapies may be considered if first-line pharmacotherapies are not effective

- Clonidine
- Nortriptyline
- Combination Therapy – patch with gum/nasal spray

**Enrollment by nurse for member with co morbidity:**

1. Planning to use stop tobacco use meds + DM condition meeting established criteria = referred to doc for meds and to DM program to be followed by nurse for stop tobacco use and DM condition.
2. Not using stop tobacco use meds, + Tobacco + DM condition meeting established criteria = referred to DM program to be followed by nurse for stop tobacco use and DM condition.

**No co morbidity (not followed by nurse):**

1. Planning to use meds and no DM condition meeting established criteria = referred to doc and community based stop tobacco use programs. If prescribed Chantix, direct member to enroll and actively participate in the Chantix stop smoking program after filling their prescription by accessing GETQUIT through [www.chantix.com](http://www.chantix.com) or by calling 1-877-242-6849. Prior auth is no longer needed effective March 2009.
2. No meds, no other condition or not sure and really need to talk to somebody in more depth = referred to Tina Blewett, Sr. Project Coordinator.

**<sup>5</sup> Tobacco Cessation Counseling/Enhancing Motivation/ Address Risk Factors/Relapse Prevention**

**Counseling** – The “5 A’s”

- Ask about tobacco use
- Advise to quit – Advice should be clear, strong, personalized
- Assess willingness to make a quit attempt – Ask if willing to make a quit attempt at this time
- Assist in quit attempt – Set a quit date, tell family and friends (optional), anticipate challenges, remove tobacco products from the environment
- Arrange follow-up as indicated per risk stratification

**Phone/Office Visit Schedule**

- Visit 1 - Baseline
- Visit 2 – 2 weeks
- Visit 3 – 2 weeks
- Visit 4 – 1 month
- Visit 5 – 1 month (at discretion of counselor for relapse prevention)

If additional visits needed, the tobacco counselor will schedule at their discretion

**Enhancing Motivation** – The “5 R’s”

- **Relevance** – Assist patient to identify their personal reason for quitting
- **Risks** – Educate about acute, long-term, and environmental risks associated with tobacco abuse

- **Rewards** – Improved health, food will taste better, improved sense of smell, save money, feel better about yourself, breaking the addiction – being in control, clothing smells better, can stop worrying about quitting, set a good example, improved appearance, feeling better physically, performing better in physical activities, having healthier babies and children
- **Roadblocks** – Withdrawal, fear of failure, weight gain, lack of support, depression, enjoyment of tobacco, limited knowledge of effective treatments, being around other tobacco users
- **Repetition** – Repeat these motivational strategies every time a patient visits the clinic setting, especially if unmotivated

### **Address Risk Factors**

- High nicotine dependence – Fagerstrom score > 7 – behavior modification and pharmacologic therapy
- Psychiatric comorbidity (includes depression, schizophrenia, alcoholism, other chemical) – consider Bupropion, work with Behavioral health
- Low motivation – Educate, address financial resources, address quitting fears and concerns, “5 R’s”
- Low readiness to change (Pre-contemplation or contemplation) – same as low motivation
- Low self-efficacy (perceived inability to quit) – Work with the member to provide a supportive clinical environment
- Environmental (other smokers in home/workplace) – educate patient to encourage housemates to quit, not smoke in their presence, remove all tobacco paraphernalia
- High stress level (stressful life circumstances and/or recent, major life change (e.g., divorce, job change, etc.) – teach alternate coping skills: deep breathing, temporary diversion, routine change, exercise, pharmacotherapy

### **Relapse Prevention**

- These interventions should be part of every encounter with a patient who has recently quit:
- The benefits of quitting
- The success the patient has had in quitting (duration of abstinence, reduction in withdrawal, etc)
- Problems encountered or anticipated threats to maintaining abstinence (depression, weight gain, alcohol, other tobacco users in the household)

**Pharmacotherapy** (Refer to Seed Clinical Practice Guideline – Treating Tobacco Use and Dependence, U.S. Department of Health and Human Services, May 2008, pp., 44-56)

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### **\*Pharmacotherapy Coverage**

- Health Plan members are responsible for the cost of over-the-counter and prescription nicotine replacement therapy
- Generic Zyban (bupropion SR) is now first line and is covered on the formulary for Health Plan members who have a prescription drug rider
- The member is responsible for the copayment at the pharmacy when filling the prescription
- Buproban is contraindicated in members treated with Wellbutrin, Wellbutrin SR or any other medication that contains bupropion (to reduce seizure risk associated with over medicating)
- There are no absolute contraindications regarding the use of other anti-depressant medication(s) when a member is using Buproban for tobacco cessation
- Chantix is first line and is covered on the formulary for Health Plan members who have a prescription drug rider
- The member is responsible for the copayment at the pharmacy when filling the prescription

- Chantix is limited to a lifetime supply of 24-weeks

**NOTE: The Food and Drug Administration (FDA) has issued reports of Chantix users experiencing side effects of drowsiness (affecting the ability to drive or operate machinery), suicidal thoughts, and aggressive and erratic behavior within days to weeks of starting Chantix treatment. Patients should be urged to report any behavior or mood changes to their doctor and urged to use caution when driving or operating machinery until they know how Chantix will affect them.**

### **Pharmacotherapy for Special Populations**

1. **Gender** – the same tobacco cessation treatments are effective for both men and women (except in the case of pregnant women)
2. **Pregnancy/Lactation** – Pharmacotherapy may be considered when a pregnant/lactating woman is otherwise unable to quit, when the likelihood of quitting, with its potential benefits outweighs the risks of the pharmacotherapy and potential continued smoking. If NRT is used, the clinician should consider monitoring blood nicotine levels to assess level of drug delivery, using medication doses that are at the low end of the effective dose range, and consider choosing delivery systems that are intermittent (nicotine gum) vs. continuous (nicotine patch). Consider Bupropion SR when risks outweigh the benefits.
3. **Racial and ethnic minorities** – provide the same tobacco cessation treatments for members of racial and ethnic minorities
4. **Psychiatric comorbidity and/or chemical dependency** – Bupropion SR and nortriptyline may be considered for the treatment of tobacco dependence in smokers with current or past history of depression. Evidence indicates that tobacco cessation interventions do not interfere with recovery from chemical dependency and standard tobacco cessation counseling and pharmacotherapy should be provided.
5. **Children and Adolescents** – Counseling and behavioral interventions shown to be effective with adults should be considered for use with children and adolescents. The content of these interventions should be modified to be appropriate for the age and development of the child. When treating adolescents, clinicians may consider bupropion SR or NRT when there is evidence of dependence and a desire to quit tobacco use.
6. **Older smokers** – Older smoker should be provided the same smoking cessation counseling and treatments as those delivered to the general population.

#### **Mayo Clinic Treatment Recommendations per Richard Hurt, MD (not evidence-based)**

Low risk – Fagerstrom 0-6; One (1) ppd or less= cold turkey, OTC gum or single dose patch

Moderate – Fagerstrom 7-8; or 30 cig/day = 2 patches (21 mg and 14 mg)

High – Fagerstrom 9-11; or 40 cig/day = two(2) 21 mg patches or more (may titrate depending per patient response)

All information (except Mayo recommendations) adapted from Treating Tobacco Use and Dependence Clinical Practice Guideline. U.S. Department of Health and Human Services. May 2008.

## **MEASURES**

Percent of members that use tobacco with Readiness to change assessed

Percent of members that use tobacco advised to quit

Percent of members that use tobacco informed of medication strategies

Percent of members that use tobacco informed of cessation strategies

Percent of PFTs in symptomatic smokers  $\geq$  age 40

Percent of members that use tobacco, are enrolled in DM programs and enrolled in tobacco cessation

One year quit rates for members enrolled in tobacco cessation program