**REQUEST TO PRESCRIBE CYTISINICLINE FOR SMOKING CESSATION**

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| GP Surgery: |  |  | Date: | 14/2/2025 |
| Patient: |  |  | D.O.B: |  |

Your patient is attending our 12-week stop smoking programme and will be receiving weekly support and monitoring. We have agreed a plan of action, and following discussion of the treatment options available, they would like to use cytisinicline (Cytisine) to support them in their quit journey.

During our initial consultation with the patient, we highlighted the contra-indications of cytisinicline to them, and they informed us that they weren’t aware of any that were applicable to them, as indicated in the table below. We also informed them of the adverse effects of the drug

However, our staff are not qualified medical professionals, and do not have access to your patient’s medical record. We would therefore request that you consider prescribing cytisinicline if appropriate.

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|  | | **Yes/No** |
| Under 18 years old or over 65 years old | |  |
| Has renal (kidney) impairment | |  |
| Has hepatic (liver) impairment | |  |
| Has unstable angina | |  |
| Has had a recent myocardial infarction (heart attack) | |  |
| Has had a recent stroke | |  |
| Has or has had clinically significant arrhythmias | |  |
| Is pregnant or breastfeeding | |  |
| Is taking anti-Tuberculosis medication | |  |
| Has a known sensitivity to cytisinicline or any of its excipients | |  |
| Points of clarification: | If female, is woman of childbearing age? (See point 2 below). |  |
| The Patient has been advised of variable dosing schedule as set out below and advised to follow the dosing leaflet with the drug packet. |  |
| ***The section above will be completed by the stop smoking practitioner***  The patient has been informed that the dose for cytisinicline is a varying schedule for 25 days and to follow the dosing information in the patient information leaflet with the medicine, and as shown here [cytisine dosing v6 (ncsct.co.uk)](https://www.ncsct.co.uk/library/view/pdf/Cytisine-summary-and-dosing-guide.pdf). | |  |

When prescribing we suggest:

1. **Prescribe as “Cytisinicline tablets 1.5mg, 1 pack of 100 tablets, dose as per recommended 25 day schedule.”**
2. Ensure women of childbearing potential understand the guidance for contraception.

Women of childbearing potential must use highly effective contraception while taking cytisinicline. Women using systemically acting hormonal contraceptives should add a second barrier method as its impact on the effectiveness of oral contraceptives is not known.

1. Prescribe dose as ‘Take as per dosing schedule set out in the patient information leaflet in box’.

The licensed dose schedule is complicated and is shown overleaf.

1. Send an AccuRx message to patients, suggested wording below:

“Cytisinicline (stop smoking medication). The dose for cytisinicline is a varying schedule for 25 days. Follow the dosing information in the patient information leaflet with the medicine, and as shown here [cytisine dosing v6 (ncsct.co.uk)](https://www.ncsct.co.uk/library/view/pdf/Cytisine-summary-and-dosing-guide.pdf).”

1. Add a note for the community pharmacist to go through the dose schedule with the patient when giving the cytisinicline to the patient, suggested wording below:

*Please explain the dosing schedule in patient information leaflet with the patient when dispensing cytisinicline.*

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| --- | --- | --- | --- |
| **Dosing Schedule for Cytisinicline (Cytisine)** | | | |
| **Days of treatment** | **Recommended dosing** | | **Maximum daily dose** |
| From the 1st to the 3rd day | 1 tablet every 2 hours | | 6 tablets |
| From the 4th to the 12th day | 1 tablet every 2.5 hours | | 5 tablets |
| From the 13th to the 16th day | 1 tablet every 3 hours | | 4 tablets |
| From the 17th to the 20th day | 1 tablet every 5 hours | | 3 tablets |
| From the 21st to the 25th day | 1-2 tablets a day | | 2 tablets |
| **Total number of tablets needed for this 25-day course:** | |  | **100 tablets** |

**If you determine that this patient is not suitable for cytisinicline, please ask the patient to contact us.**

Please do not hesitate to contact me if you have any questions.

Yours sincerely,

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| --- | --- | --- | --- | --- |
| Name of practitioner: |  |  | Tel: |  |

Pharmacy / Practice / Group: