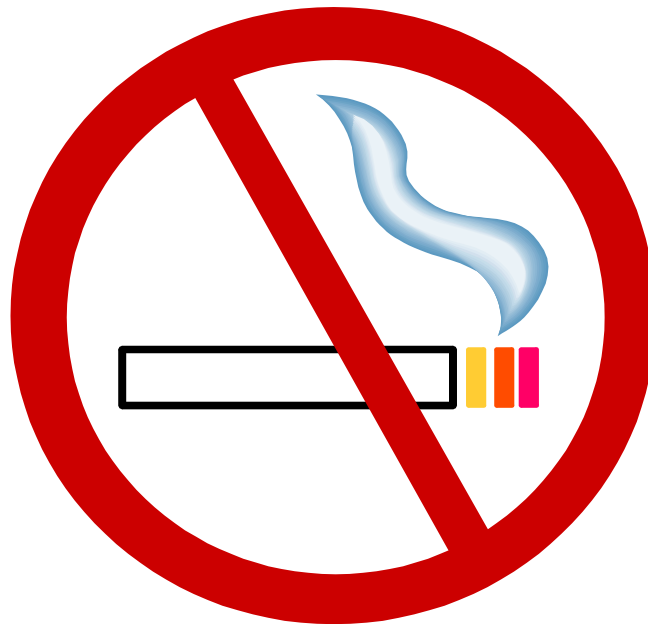


INTEGRATED CARE FOR SMOKING CESSATION

Treatment for Veterans with PTSD



Smoking Cessation Medication Algorithm

Medication Algorithm for Integrated Care (IC)

The Medication Algorithm for patients receiving IC is generally based upon the Public Health Service clinical practice guideline, *Treating Tobacco Use and Dependence* (http://www.surgeongeneral.gov/tobacco/treating_tobacco_use08.pdf). While providing some specific evidenced based pharmacotherapy recommendations, the Guideline leaves some latitude for clinicians and patients to make individualized determinations about pharmacotherapy approaches. The Guideline does suggest that every smoker, except possibly pregnant smokers and adolescents, should be encouraged to use pharmacotherapies. Likewise, IC does not dictate specific pharmacologic interventions, but appropriate, individualized pharmacotherapy is recommended unless specific contraindications exist or the patient refuses pharmacotherapy.

Although pharmacotherapy is individualized, one purpose of this algorithm is to promote reasonable consistency in the prescribing of smoking cessation medications. It must be pointed out that all patients receiving IC, by virtue of the fact that they have PTSD, fall under the “Special Populations/Psychiatric Comorbidity” section of the Guideline. The Guideline acknowledges that there are not extensive data to guide choice of pharmacotherapies in this special population. The Guideline recommends seven first line therapies, five of which are VA formulary medications: bupropion SR (or at some medical centers bupropion immediate release [IR]), transdermal nicotine, and nicotine gum, nicotine lozenge, and varenicline. Because of the lack of sufficient data to rank-order these medications, choice of a specific first-line pharmacotherapy must be guided by factors such as clinician familiarity with the medications, contraindications for selected patients, patient preference, previous patient experience with a specific pharmacotherapy (positive or negative), and patient characteristics (e.g., history of depression, concerns about weight gain).

The other two first line pharmacotherapies, nicotine nasal spray and nicotine inhaler, are non-VA formulary medications that are used for the small number of patients who elect nicotine replacement therapy but cannot tolerate transdermal nicotine or nicotine polacrilex. When indicated (as described below in sections 4A and 5A of this document), these medications can be obtained for patients via a non-formulary drug request.

It is recognized that the Clinical Practice Guideline may be updated periodically. Clinicians delivering IC should refer to the most recent version of the Guideline for the most up to date medication information.

1. Bupropion SR (or IR if SR is non-formulary)

A. Who can receive bupropion SR (or IR)?

Any patient may receive bupropion SR unless absolute contraindications exist or unless the patient refuses the medication. The absolute contraindications are:

1. Hypersensitivity to bupropion
2. Bulimia
3. Anorexia
4. Monoamine oxidase inhibitor use within 14 days
5. Seizure disorder
6. Already taking bupropion (Wellbutrin)

If any of the numerous relative contraindications or cautions regarding use of bupropion exist (e.g. other medications with which there could be a drug-drug interaction), it is left to the discretion of the clinician to determine if bupropion should be prescribed.

B. Initiating bupropion SR

1. Bupropion SR is initiated 7 days prior to the planned quit date.
2. Bupropion SR is initiated at 150 mg q d x 3d.
 - a. If, during the course of the first 3 days of treatment, it becomes evident that the patient is not able to tolerate bupropion SR 150 mg q d, bupropion SR should be discontinued.
 - b. At any later date (see continuation treatment below) it is always possible to attempt again to initiate at 150 mg qd.
3. After 3 days the dose is increased to 150 mg bid
 - a. If a dosage increase is not tolerated, the dosage should be reduced and maintained at 150 mg q d.
 - b. At any later date it is always possible to increase again to 150 mg bid.

C. Continuation treatment with bupropion SR

1. All patients who are successfully initiated onto bupropion SR can be maintained on bupropion SR for a minimum of 12 weeks unless intolerable side effects supervene.
 - a. If intolerable side effects supervene, the dosage should be reduced to 150 mg q d.
 - b. If intolerable side effects supervene, and the patient is already on 150 mg q d or has already been reduced to 150 mg q d, bupropion SR should be discontinued.

B¹. Initiating bupropion IR

1. Bupropion IR is initiated 7 days prior to the planned quit date.
2. Bupropion IR is initiated at 100 mg bid x 3d.
 - a. If, during the course of the first 3 days of treatment, it becomes evident that the patient is not able to tolerate bupropion IR 100 mg bid, bupropion IR should be discontinued.
 - i. If bupropion IR is not tolerated, a trial on bupropion SR is indicated. A non-formulary drug request should be initiated, and the algorithm for bupropion SR should be followed.
 - b. At any later date it is always possible to attempt again to initiate bupropion IR 100 mg bid.
3. After 3 days the dose is increased to 100 mg tid
 - a. If a dosage increase is not tolerated, the dosage should be reduced and maintained at 100 mg bid or consideration can be given to placing a non-formulary request for bupropion SR.
 - b. At any later date it is always possible to increase again to 100 mg tid.

C¹. Continuation treatment with bupropion IR

1. All patients who are successfully initiated onto bupropion IR can be maintained on bupropion IR for a minimum of 12 weeks unless intolerable side effects supervene.
 - a. If intolerable side effects supervene, the dosage should be reduced to 100 mg bid or consideration may be given to initiating a non-formulary drug request for bupropion SR.
 - b. If intolerable side effects supervene, and the patient is already on 100 mg bid or has already been reduced to 100 mg bid, bupropion IR should be discontinued, and consideration may be given to initiating a non-formulary drug request for bupropion SR.
2. The Guideline states that long-term use of tobacco dependence pharmacotherapies “. . . may be helpful with smokers who report persistent withdrawal symptoms during the course of medications, who have relapsed in the past after stopping medication, or who desire long-term therapy” and that “the FDA has approved the use of bupropion SR, varenicline, and some NRT medications for 6-month use,” and that “For long-term therapy, consider use of bupropion SR 150 mg for up to 6 months postquit.” Thus, all patients who desire to remain on bupropion SR (or IR) past the minimum treatment period of 12 weeks and who are safely tolerating the medication can be permitted to do so, at clinician discretion, an approach that is

consistent with the Guideline. Some patients who successfully quit smoking and may no longer need bupropion for smoking cessation may wish to continue it for its benefit on psychiatric symptoms. In these cases, patients should be changed from the Zyban brand of the medication to the Wellbutrin brand.

2. Transdermal Nicotine

A. Who can receive transdermal nicotine?

All patients may receive transdermal nicotine unless absolute contraindications exist or unless the patient refuses the medication. The absolute contraindications are:

1. Hypersensitivity to nicotine patch
2. Recent (within 2 weeks) MI or severe arrhythmia
3. Unstable angina
4. Pregnancy

B. Initiating transdermal nicotine

1. Transdermal nicotine is initiated on the patient's planned quit date.
2. Transdermal nicotine initially is prescribed at 21 mg/24 hours. However, as per the Guideline "Clinicians should consider individualizing treatment based on specific patient characteristics such as previous experience with the patch, amount smoked, degree of addictiveness, etc." Thus, treatment with higher doses of transdermal nicotine is not specifically proscribed.
 - a. If intolerable side effects supervene, the appropriate steps to take depend on the side effects.
 - i. If the side effect is sleep disturbance, patients should be instructed to remove the patch prior to going to sleep.
 - ii. For mild skin irritation patients should be encouraged to change the patch site and use 1% hydrocortisone cream.
 - iii. For any other types of side effects, the dosage should be reduced to the next lowest dosage. If the dosage is 21 mg/24 hours and side effects supervene, the dosage should be reduced to 14 mg/24 hours and then to 7 mg /24 hours and then discontinued if side effects continue.

C. Continuation treatment with transdermal nicotine

1. All patients who are successfully initiated and stabilized on transdermal nicotine can be maintained on their stable dose for a planned treatment exposure of 8 weeks unless intolerable side effects supervene.
 - a. If intolerable side effects supervene, dosage should be titrated downward as described in section 2.B.2.i above.

2. The Guideline states that in regard to transdermal nicotine, "Treatment of 8 weeks or less has been shown to be as efficacious as longer treatment periods." However, the Guideline also states that long-term use of tobacco dependence pharmacotherapies ". . . may be helpful with smokers who report persistent withdrawal symptoms during the course of medications, who have relapsed in the past after stopping medication, or who desire long-term therapy." Thus, treatment with transdermal nicotine beyond the targeted exposure period of 8 weeks is neither encouraged nor proscribed but is left to clinician discretion.

D. Discontinuation of transdermal nicotine

1. Tapering can be accomplished, if desired, by incrementally lowering the dosage of transdermal nicotine through use of 14 mg and 7 mg patches. Since data do not support any specific tapering schedule, the tapering schedule for each patient is left to clinician discretion.

3. Nicotine Polacrilex (Gum and Lozenge)

A. Who can receive nicotine polacrilex?

All patients may receive nicotine polacrilex as gum for prn use unless absolute contraindications exist or unless the patient refuses the medication. The absolute contraindications are:

1. Recent (within 2 weeks) MI or severe arrhythmia
2. Unstable angina
3. Pregnancy

Patients who cannot tolerate nicotine gum may receive nicotine polacrilex as a lozenge.

Some patients who refuse transdermal nicotine or who cannot tolerate transdermal nicotine because of dermatological side effects may use nicotine polacrilex as their sole nicotine replacement, and it would be recommended as a scheduled rather than a prn medication.

B. Initiating nicotine polacrilex for **patients on transdermal nicotine**

1. Nicotine polacrilex is initiated on the patient's designated quit date.
2. Nicotine polacrilex initially is prescribed as 2 mg gum or lozenge q 1-2 hours prn nicotine craving. Since most patients also are receiving transdermal nicotine, the maximum dose of nicotine polacrilex is 12 pieces or lozenges (24 mg)/24 hours.
 - a. If intolerable side effects supervene, patients should be encouraged to reduce the dosage or discontinue nicotine polacrilex.

- b. If patients experience intense craving 4 mg gum or lozenge prn may be used in this situation.

C. Initiating nicotine polacrilex for **patients who are not prescribed transdermal nicotine**

1. Nicotine polacrilex is initiated on the patient's designated quit date.
2. As per the Guideline nicotine polacrilex initially is prescribed at 2 mg q 2 h while awake for patients who smoke <25 cigarettes per day; at 4 mg q 2 h while awake for patients who smoke \geq 25 cigarettes per day.
3. The maximum dose of nicotine polacrilex for patients not receiving transdermal nicotine is generally 24 pieces or lozenges (48-96mg)/24 hours
4. Patients not on transdermal nicotine may also receive prn nicotine polacrilex as described in section 3.B.2 above. (e.g. for patients on bupropion) up to the maximum of 24 pieces or lozenges/24hours.
5. Continuation treatment and tapering of nicotine polacrilex for patients not on transdermal nicotine is as described for patients on transdermal nicotine in sections 3.D and 3.E below.

D. Continuation treatment with nicotine polacrilex

1. The Guideline states that long-term use of tobacco dependence pharmacotherapies “. . . may be helpful with smokers who report persistent withdrawal symptoms during the course of medications, who have relapsed in the past after stopping medication, or who desire long-term therapy.” Specifically in regard to prn medications the Guideline states that “A minority of individuals who successfully quit smoking use ad libitum NRT medications (gum, lozenge, nasal spray, inhaler) long-term. The use of these medications long-term does not present a known health risk.” The Guideline does not suggest a specific time frame over which nicotine polacrilex should be prescribed. Thus, patients who are successfully initiated on nicotine polacrilex may, at clinician discretion, continue nicotine polacrilex as a prn medication not to exceed 24 pieces or lozenge/day for periods longer than is usually recommended.

E. Tapering of nicotine polacrilex

1. Nicotine polacrilex dosage should be lowered by reducing the amount prescribed by 25% per week over 4 weeks.
2. Patients who have tapered off nicotine polacrilex may resume prn use if needed anytime per clinician discretion.

4. Nicotine Nasal Spray

A. Who can receive nicotine nasal spray?

Patients who cannot tolerate the use of nicotine polacrilex may receive nicotine nasal spray for prn use unless absolute contraindications exist or unless the patient refuses the medication. (Patients who cannot tolerate nicotine polacrilex may receive either nicotine nasal spray or a nicotine inhaler [see Section 5 below] via a non-formulary drug request.) Thus, nicotine nasal spray is prescribed rarely. Very rarely some patients who refuse transdermal nicotine or who cannot tolerate transdermal nicotine because of dermatological side effects and also cannot tolerate nicotine polacrilex can receive nicotine nasal spray as their sole nicotine replacement and take it as a scheduled rather than a prn medication. The reason why patients cannot tolerate nicotine polacrilex would typically be that they are edentulous or develop teeth or jaw problems with use of nicotine polacrilex. The absolute contraindications for nicotine nasal spray are:

1. Recent (within 2 weeks) MI or severe arrhythmia
2. Unstable angina
3. Severe reactive airways disease
4. Pregnancy

B. Initiating nicotine nasal spray for patients who *are* prescribed transdermal nicotine

1. Nicotine nasal spray is initiated on the patient's planned quit date.
2. Nicotine nasal spray initially is prescribed as 1 spray (0.5 mg) in each nostril q 1-2 h prn nicotine craving. Since most patients also are receiving transdermal nicotine, the maximum dose of nicotine nasal spray is 24 sprays in each nostril (24 mg)/24 hours.
 - a. If intolerable side effects supervene, patients should be encouraged to reduce the dosage or discontinue nicotine nasal spray.

C. Initiating nicotine nasal spray for patients *not on* transdermal nicotine (only patients who cannot tolerate the use of nicotine polacrilex and transdermal nicotine may receive nicotine nasal spray as the sole nicotine replacement therapy.)

1. Nicotine nasal spray is initiated on the patient's designated quit date.
2. As per the Guideline nicotine nasal spray initially is prescribed as 1 spray (0.5 mg) in each nostril 1-2 times per hour, increasing as needed for symptom relief. Minimum recommended treatment is 8 doses/day, with a maximum limit of 40 doses/day (5 doses/hr).
3. Continuation treatment and tapering of nicotine nasal spray for patients not on transdermal nicotine is as described for patients on transdermal nicotine in sections 4.C and 4.D below.

D. Continuation treatment with nicotine nasal spray

1. See Section 3.D.1 above for information about continuation therapy with nicotine replacement. Patients who are successfully initiated on nicotine nasal spray may, at clinician discretion, continue nicotine nasal spray as a prn medication not to exceed 40 sprays/day for periods longer than is usually recommended.

E. Tapering of nicotine nasal spray

1. It is suggested to patients on nicotine nasal spray that their dosage be lowered by reducing the amount used by 25% per week over 4 weeks.
2. Patients who have tapered off nicotine nasal spray may resume prn use if needed anytime at clinician discretion.

5. Nicotine Inhaler

A. Who can receive nicotine inhaler?

Patients who cannot tolerate the use of nicotine polacrilex may receive nicotine inhaler for prn use unless absolute contraindications exist or unless the patient refuses the medication. (Patients who cannot tolerate nicotine polacrilex may receive either nicotine nasal spray [see Section 4 above] or a nicotine inhaler via a non-formulary drug request.) Thus, nicotine inhaler is prescribed very rarely. Even more rarely some patients who refuse transdermal nicotine or who cannot tolerate transdermal nicotine because of dermatological side effects and also cannot tolerate nicotine polacrilex can receive nicotine inhaler as their sole nicotine replacement and take it as a scheduled rather than a prn medication. The absolute contraindications for nicotine inhaler are:

1. Recent (within 2 weeks) Acute MI or severe arrhythmia
2. Unstable angina
3. Pregnancy

B. Initiating nicotine inhaler for **patients who are prescribed transdermal nicotine**

1. Nicotine inhaler is initiated on the patient's planned quit date.
2. Nicotine inhaler initially is prescribed as 1 inhalation prn for nicotine craving. Since most patients also are receiving transdermal nicotine, the maximum dose of nicotine inhaler is 6 cartridges (24 mg)/24 hours. (Each cartridge contains a total of 4 mg nicotine delivered over 80 inhalations).
 - a. If intolerable side effects supervene, patients are encouraged to reduce the dosage or discontinue nicotine inhaler.

C. Initiating nicotine inhaler for **patients who are not prescribed transdermal nicotine (only patients who cannot tolerate the use of nicotine polacrilex and transdermal nicotine may receive nicotine inhaler as the sole nicotine replacement therapy.)**

1. Nicotine inhaler is initiated on the patient's designated quit date.
2. As per the Guideline nicotine inhaler initially is prescribed as 1 puff prn, increasing as needed for symptom relief. Minimum recommended treatment is 6 cartridges (480 inhalations)/day, with a maximum limit of 16 cartridges (1280 inhalations)/day.
3. Continuation treatment and tapering of nicotine inhaler for patients not on transdermal nicotine is as described for patients on transdermal nicotine in sections 5.D and 5.E below.

D. Continuation treatment with nicotine inhaler

1. See Section 3.D.1 above for information about continuation therapy with nicotine replacement. The Guideline does suggest that, in general the nicotine inhaler should be prescribed for up to 6 months with tapering during the final 3 months. Thus, patients who are successfully initiated on the nicotine inhaler may, at clinician discretion, continue the nicotine inhaler as a prn medication not to exceed 10 cartridges/day for periods longer than is usually recommended.

E. Tapering of the nicotine inhaler

1. The nicotine inhaler should be tapered over 3 months by decreasing the number of cartridges prescribed by 30-40% each month and then discontinuing it.
2. Patients who have tapered off the nicotine inhaler may resume prn use if needed anytime per clinician discretion.

6. Varenicline

A. Who can receive varenicline?

At the present time the VA limits varenicline to patients who cannot tolerate other smoking cessation medications or who have failed adequate trials of other smoking cessation medications. There have been reports of serious psychiatric adverse events, including thoughts of and attempted suicide, in patients currently or recently receiving varenicline. As a result, additional VA restrictions are in place for patients with mental health conditions:

VA Exclusion Criteria:

1. Patients whose smoking cessation monitoring is via non-VA telephone counseling (e.g. a state telephone quit-line).
2. Patients who wish to receive varenicline based on a prescription written by a non-VA prescriber.

3. Patients with a history of suicidal, homicidal, or assaultive behavior within the previous 12 weeks.
4. Patients with current, persistent suicidal or homicidal ideation or an active plan or intent to harm self or others.
5. Patients with an untreated or unstable mental disorder such as, but not limited to, psychotic disorder, bipolar disorder, major depressive disorder, and PTSD.

VA Inclusion Criteria:

1. The mental disorder is clinically stable.
2. The prescribing clinician has concurrence from the patient's mental health provider for varenicline treatment.
3. The patient is monitored by a health care provider at least every 28 days in person or by telephone. Health care providers should monitor changes in behavior and mood and document any of these changes in the medical record.
4. Health care providers educate veterans and families, if available, prior to starting varenicline about the possibility of changes in behavior or mood and particularly any thoughts of suicide, homicide, assault, self harm, or harm to others. The veteran or family member should immediately report such changes or thoughts to the provider, stop the varenicline, and/or seek urgent or emergent evaluation and care. In addition, communicate warnings about driving and operating heavy machinery due to the potential for loss of consciousness, seizures, muscle spasms, visual disturbances or hallucinations.

In addition to the restrictions above, varenicline should be used with caution in individuals with renal impairment.

B. Initiating varenicline

1. Varenicline is initiated 7 days prior to the planned quit date.
2. Varenicline is initiated at 0.5 mg q d x 3d.
 - a. If, during the course of the first 3 days of treatment, it becomes evident that the patient is not able to tolerate varenicline 0.5 mg qd, varenicline should be discontinued.
 - b. At any later date (see continuation treatment below), it is always possible to attempt again to initiate 0.5 mg qd.
3. After 3 days the dose is increased to 0.5 mg bid
 - a. If a dosage increase is not tolerated, the dose may be lowered temporarily or permanently.

- b. At any later date (see continuation treatment below), it is always possible to attempt again to increase to 0.5 mg bid and follow the algorithm.
- 4. On the quit date (7 days after initiating varenicline treatment) the dosage is increased to 1 mg bid.
 - a. If 1 mg bid is not tolerated, the dose may be lowered temporarily or permanently.
 - b. At any later date (see continuation treatment below), it is always possible to attempt again to increase to 1 mg bid and follow the algorithm.

C. Continuation treatment with varenicline

1. All patients who are successfully initiated onto varenicline can be maintained on varenicline for a minimum of 12 weeks unless intolerable side effects supervene.
 - a. If intolerable side effects supervene, varenicline dosage can be reduced to 0.5 mg bid or 1 mg q day.
 - b. At any later date, it is always possible to attempt again to increase to 1 mg bid and follow the algorithm.
2. Patients who have a positive response to varenicline up to 12 weeks may be continued on varenicline for an additional 12 weeks for a total of 24 weeks of treatment.
 - a. Per current VA guidelines, “If the patient stops smoking by week 12, an additional 12 weeks of therapy may increase the likelihood of long term abstinence. A course of therapy with varenicline beyond 24 weeks is unstudied and is not recommended.”

D. Discontinuation of Varenicline

1. At or before 24 weeks of treatment with varenicline, varenicline should be discontinued. Generally no taper is required, although it is acceptable to taper by using 0.5 mg bid x 4 d, then 0.5 mg q d x 3 d, then D/C.

7. Combining smoking cessation pharmacotherapies

A. Combining transdermal nicotine and nicotine polacrilex

1. The Guideline states that “. . . the combination of long-term patch use + ad libitum NRT (gum or spray) [was] . . . found to produce significantly greater likelihood of long-term abstinence than the patch by itself.”
2. Thus, combined prescription of both transdermal nicotine and nicotine polacrilex is encouraged, though not required, when nicotine replacement is used.

B. Combining bupropion SR (or IR) and transdermal nicotine

1. The Guideline states that combining bupropion SR and nicotine patch is an effective treatment.
2. There is no evidence that the combination of bupropion SR (or IR) and transdermal nicotine is unsafe or that it leads to a greater number of or to more severe adverse events.
3. Thus, the combination of bupropion SR (or IR) and transdermal nicotine is encouraged, though not required.

C. Combining bupropion SR or (IR), transdermal nicotine, and nicotine polacrilex (or nicotine nasal spray or inhaler if used in place of nicotine polacrilex)

1. No data exist to suggest that this combination is more efficacious than nicotine replacement or bupropion SR (or IR) alone, or bupropion SR (or IR) and nicotine patch in combination.
2. Thus, the combination of bupropion SR (or IR), transdermal nicotine, and nicotine polacrilex is neither be encouraged nor proscribed but is left to clinician discretion.

D. Varenicline should NOT be combined with other smoking cessation

pharmacotherapies. Varenicline occupies one subtype of nicotinic receptor and blocks some effects of nicotine and/or increases side effects of nicotine. There are no known interactions between bupropion and varenicline, but the safety and efficacy of the combination have not been established. Per the Guideline combining varenicline with NRT agents has been associated with higher rates of side effects (e.g., nausea, headaches). Per current VA guidelines, "Until more data are available, varenicline should NOT be used in combination with NRT or bupropion (when its sole use is for smoking cessation).

8. Long-term use of pharmacotherapies

- A. According to the Guideline, "For some patients, it may be appropriate to continue medication treatment for periods longer than is usually recommended." Studies indicate that "long-term patch and gum use are effective" and use of nicotine gum for up to 5 years results in "no serious side effects." Guideline authors conclude, "it may be that certain groups of smokers may benefit from long-term medication use. Although weaning should be encouraged for all patients using medications, continued use of such medication clearly is preferable to a return to smoking with respect to health consequences. This is because, unlike smoking, these medications do not (a) contain non-nicotine toxic substances (e.g., "tar," carbon monoxide, formaldehyde, benzene); (b) produce sharp surges in blood nicotine levels; and/or (c) produce strong dependence. . . Finally, it should be noted that the medication treatment that produced the largest effects on abstinence rates, of those analyzed, involved long-

term nicotine patch therapy + ad libitum NRT. . ." Thus, long-term use of medications may be clinically appropriate for some patients receiving IC.

9. Restarting discontinued pharmacotherapies

- A. Patients who discontinue pharmacotherapy and resume smoking after quitting or continue smoking may restart smoking cessation pharmacotherapies using the procedures outlined in points 1-6 above.

10. Patients who smoke while receiving smoking cessation pharmacotherapies

- A. Patients who receive nicotine replacement are instructed not to smoke in part because of potential toxicity but more importantly because concomitant nicotine replacement and smoking decrease the likelihood of successful quitting. Nevertheless, many patients who get nicotine replacement do smoke. In most cases this occurrence does not represent a serious risk. If smoking continues, the clinician must determine whether or not to continue nicotine replacement. Since no specific data exist to guide practice in this circumstance, such a decision is left to the discretion of the clinician. However, long-term concurrent smoking and NRT should be discouraged.
- B. There is no evidence that smoking while on bupropion SR (or IR) is dangerous. (In fact, smokers should use bupropion SR [or IR] for 7 to 14 days prior to making a quit attempt.) No specific data exist to provide guidance on the benefits of continuing bupropion SR in the face of ongoing smoking. Thus, clinicians have to make a judgment regarding the wisdom of continuing bupropion SR (or IR) in the face of ongoing smoking. Clinicians should balance the potential benefit of bupropion SR (or IR) in ultimately leading to smoking cessation versus the costs and any potential side effects of bupropion SR (or IR).
- C. There is no evidence that smoking while on varenicline is seriously dangerous, but it is likely to result in more severe nicotine side effects. No specific data exist to provide guidance on the benefits of continuing varenicline in the face of ongoing smoking. Thus, clinicians have to make a judgment regarding the wisdom of continuing varenicline in the face of ongoing smoking. Clinicians should balance the potential benefit of varenicline in ultimately leading to smoking cessation versus the costs and any potential side effects of smoking while on varenicline.