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# PEI Smoking Cessation Program (SCP): Overview

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Provincial Tobacco Control Coordinator  
Health Promotion Unit  
Chief Public Health Office  
Department of Health and Wellness

# Introduction

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- SCP Overview
- Program Forms
- SCP Enrollment
- Education/Resources





# PEI Smoking Cessation Program

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- The PEI Smoking Cessation Program helps PEI residents who wish to stop smoking, vaping, using other tobacco products by covering 100% of the cost of nicotine replacement therapy (NRT) or specific smoking cessation prescription medications.
- Access via healthcare services (acute care, community based) and community pharmacies
- Once per year, eligible PEI residents can receive a single continuous course (minimum 6 weeks to maximum 18 weeks in a row) of treatment.



# *Ottawa Model for Smoking Cessation*

## ASK

Ask and document tobacco use status for all clients.

## ADVISE

Use a standard message to reinforce the benefits of quitting – can be tailored for maximum impact.

## ASSESS

Readiness to quit, confidence, behavioural patterns, and level of addiction.

## ASSIST

Provide:  
Pharmacotherapy (NRT, Meds)  
Counselling  
Self-help materials

## ARRANGE

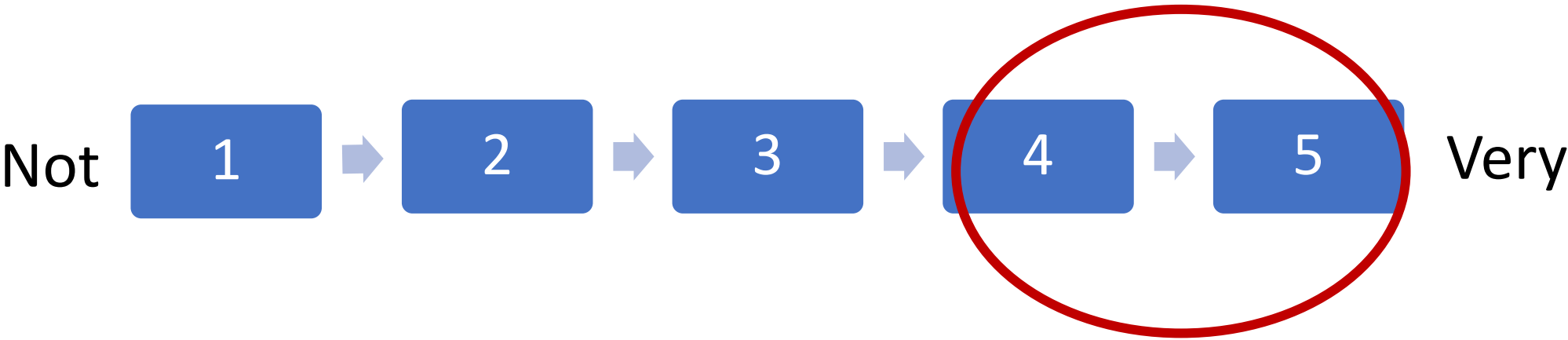
Follow-up support to monitor effectiveness, provide support and modify treatment plan.

**An evidence-based approach that can be used in all healthcare settings.**



# Readiness To Quit:

Using Scaling as an  
Assessment Tool:  
**Importance and Confidence**



- Level 4 or 5 indicates readiness to quit
- Readiness completed within 30 days of quit date



# Cessation Support Works

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## Two components

- Nicotine Replacement Therapy (NRT) or Prescription Medications (bupropion, varenicline)
- Counselling

NRT or Meds  
+ Counselling



**Triple the odds of quitting (~30%)**



# Changes in Coverage

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- Patients may switch course of treatment or between one dosage strength to another within **30 days** of starting their treatment.
  - New Intake Form [action plan] must be completed. Send to pharmacare and patients' pharmacy
  - Approval by provincial tobacco control coordinator is not required
- Follow up: Offer 1-2 weeks after initial consultation (recommend 3 follow ups after program start)
- **If beyond 30 days, changes will not be accommodated.**
- Travel supply



# Special Circumstances:

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## Early Re-enrollment

- There may be exceptions to Islanders wanting to enroll more than once per calendar year, please reach out to the Tobacco Control Coordinator to review it on a case-by-case basis.

## Age of consent:

- a) No minimum age to enroll.
- b) Consideration for prescribing NRT for youth under 18 - moderately or severely addicted to nicotine and motivated to quit.
- c) If NRT is prescribed and in the best interest of the patient—where the benefits outweigh the risks—the responsibility for the decision lies with the provider.





# Roles and Responsibilities

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Role	Responsibilities
Patient/Client	Express interest, consent to enroll, use NRT or prescription medication
Provider	Screen, assess readiness for quitting, complete consult form, educate, track progress, Submit forms, liaison with CPHO Follow-ups at 2, 6, 10 weeks (recommendation)
Pharmacare	Enroll eligible patients (ex. Ready to quit; PEI Health Card; not enrolled in the program within the past 12 months).
CPHO	Submit form to pharmacare and manually enter Consult Form into PHDMS (database)
Pharmacy	Dispense approved NRT or Rx

# Consult Form: Paper

## Eligibility:

1. Must answer 4 or 5 to questions #11 and # 12;
2. Must be interested in quitting in the next month;
3. Must be willing to set a quit date **(within 30 days of consult date);**
4. Valid PEI Health Card

**Smoking Cessation Program: Consult Form – Primary Care**

**Health PEI**  
One Island Health System  
**Santé Î.-P.-É.**  
Un système de santé unique

**Fax form: PEI Smoking Cessation Program**  
902-620-3354

Date: DD/MM/YY  
(fill in below or apply patient label)  
Patient PHN/MRN: \_\_\_\_\_  
First Name: \_\_\_\_\_  
Last Name: \_\_\_\_\_  
Date of Birth: DD/MM/YY  
Gender: ☐ Male ☐ Female ☐ Identify as: \_\_\_\_\_  
(If no contact info on patient label, also fill in below)  
Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Tel: \_\_\_\_\_ Email (if available): \_\_\_\_\_

LOCATION: ☐ Kings PC ☐ Queens East PC ☐ Queens West PC ☐ East Prince PC ☐ West Prince PC ☐ PEI Cancer Treatment Centre  
☐ Cardiac and Pulmonary Rehab ☐ Acute Care ☐ Home Care ☐ Lennox Island

**TOBACCO AND VAPE PRODUCT USE HISTORY**  
Please complete the following questions:

1. Have you used any form of tobacco or vape products in the past 6 months? ☐ Yes ☐ No (If YES, continue)
2. Have you used any form of tobacco or vape products in the past 7 days? ☐ Yes ☐ No (If YES, continue)
3. What form(s) of tobacco do you currently use? ☐ Cigarettes ☐ Cigars ☐ Pipes ☐ Smokeless ☐ Vaping Device  
☐ Other: \_\_\_\_\_
4. How much do you smoke/vape per day? (# of cigarettes/cigars/vapes, etc.) \_\_\_\_\_ (# per day/mg)  
If not a daily smoker/vaper, how much per month? \_\_\_\_\_ (# per month)
5. How many years have you smoked/vaped? \_\_\_\_\_ years
6. How many minutes after waking up do you first smoke/vape? \_\_\_\_\_ (# of minutes)
7. How many quit attempts (lasting equal to or greater than 24 hours) have you made in the past year? \_\_\_\_\_  
(a) How many of these quit attempts were supported with NRT or medication? \_\_\_\_\_  
(b) What has been your longest quit attempt (e.g. days/weeks/months, etc.)? \_\_\_\_\_
8. What previous smoking cessation methods have you tried?  
☐ Cessation Medication ☐ Patch ☐ Other NRTs ☐ "Cold Turkey" ☐ Other: \_\_\_\_\_
9. Do you currently use vaping devices (e.g. E-cigarettes, vape pens, etc.)? ☐ Yes ☐ No  
a. If yes, do you use vaping devices as a cessation aid? ☐ Yes ☐ No
10. Do others smoke in the home? ☐ Yes ☐ No
11. In which of these settings are you regularly exposed to second-hand smoke? (check all that apply)  
☐ At Home ☐ At School ☐ In the Car ☐ At Work ☐ At Social Events ☐ Other: \_\_\_\_\_ ☐ Not Exposed
12. How important is it to you to quit smoking/vaping? Please circle (not) 1 2 3 4 5 (very)
13. How confident are you that you can quit smoking/vaping? Please circle (not) 1 2 3 4 5 (very)

Provide personalized advice to quit smoking ☐ Yes ☐ No

Is patient ready to quit smoking/vaping? ☐ YES ☐ NO

Quit Date: DD/MM/YY

☐ Has quit within the last 6 months ☐ Is planning to quit in the next 6 months

☐ Is planning to quit today ☐ Is not ready to quit in the next 6 months

☐ Is planning to quit in the next month

*\*Patient must answer 4 or 5 to questions #12 and # 13, must be interested in quitting in the next month, and must be willing to set 1 quit date for enrollment into the Provincial Smoking Cessation Program.*

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SELECT QUIT SMOKING MEDICATION		Reviewed Contraindications				
<input type="checkbox"/> Nicotine Replacement Therapy (NRT)	<input type="checkbox"/> cigarettes smoked/day <input type="checkbox"/> Long Acting NRT Patch	<10 cigs/day	10-19 /day	20-29 /day	30-39 /day	40+ /day
Dose and duration of NRT should be titrated based on patient's needs	Starting Dose: *Smoke within 30 minutes of waking, add 7 mg to initial starting dose.	7 mg	14 mg	21 mg	35 mg	42 mg
<input type="checkbox"/> Short Acting NRT	<input type="checkbox"/> Inhaler <input type="checkbox"/> Gum (2mg or 4mg) <input type="checkbox"/> Lozenge (2mg or 4mg) <input type="checkbox"/> Spray (2mg or 4mg)					
<input type="checkbox"/> Varenicline <input type="checkbox"/> Bupropion <input type="checkbox"/> Review appropriate use, dose, duration of medication	Notes: <input type="checkbox"/> No medication	For use on own or combined with patch (PRN) (Note: Patients are only covered for one method under the Smoking Cessation Program)				
VAPING CESSATION ASSESSMENT: coverage limited to NRT products and does not cover prescription medications. *If unsure of light or heavy user, choose 21mg (moderate vape user)						
<input type="checkbox"/> Light Vape User (0-20mg per day): 14mg Periodic use; no cravings; withdrawal symptoms	<input type="checkbox"/> Moderate Vape User (20-40mg per day): 21 mg Stable use; habitual cravings; withdrawal symptoms; vape within 30 minutes of waking	<input type="checkbox"/> Heavy Vape User (40mg+ per day): 35 mg Increasing use; intolerable cravings; withdrawal symptoms; vape within 30 minutes of waking				
STRATEGIC ADVICE						
<input type="checkbox"/> Remind to cut back on caffeine consumption 50% on quit date <input type="checkbox"/> Review common risks of relapse (stress, alcohol, other smokers) <input type="checkbox"/> Recommend strategies for managing cravings and withdrawal				<input type="checkbox"/> Explain that changes in mood may occur in the short term <input type="checkbox"/> Provide Quit Kit and other resources <input type="checkbox"/> Offer follow up/additional supports		
ARRANGE FOLLOW-UP						
Provider Follow-up: <input type="checkbox"/> 3 days after quit date <input type="checkbox"/> 7 days after quit date <input type="checkbox"/> 14 days after quit date						
Additional option: <input type="checkbox"/> Smokers' Helpline: Fax Smokers' Helpline referral form <input type="checkbox"/> Yes <input type="checkbox"/> No						
Assess Risk for COPD if >age 40 <input type="checkbox"/> Patient has a diagnosis of COPD <input type="checkbox"/> Canadian Lung Health Test completed						

**PATIENT ACKNOWLEDGMENT**  
☐ I understand that the PEI Department of Health and Wellness may contact me for the purposes of program evaluation. My participation in a follow-up survey is completely voluntary and my decision to participate will not affect the services I receive through this program.

# Action Plan (Intake Form for Drug Cost Assistance): Paper

-To be completed at the same time as the consult form

-Sent to Pharmacare for program enrollment/eligibility

-Also completed for any product changes within 30 days of starting the program

**Smoking Cessation Program: Intake Form for Drug Cost Assistance**

**Health PEI**  
One Island Health System

**Santé Î.-P.-É.**  
Un système de santé unique

Fax form to: Client's Pharmacy,  
PEI Smoking Cessation Program  
902-620-3354,  
and PEI Pharmacare  
902-368-4905

Date: DD/MM/YYYY  
(fill in below or apply patient label)  
Patient PHN/MRN: \_\_\_\_\_  
First Name: \_\_\_\_\_  
Last Name: \_\_\_\_\_  
Date of Birth: DD/MM/YYYY

Gender: ☐ Male ☐ Female ☐ Identify as: \_\_\_\_\_  
(If no contact info on patient label, also fill in below)  
Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Tel: \_\_\_\_\_ Email (if available): \_\_\_\_\_

LOCATION: ☐ Kings PC ☐ Queens East PC ☐ Queens West PC ☐ East Prince PC ☐ West Prince PC ☐ PEI Cancer Treatment Centre  
☐ Cardiac and Pulmonary Rehab ☐ Acute Care ☐ Home Care ☐ Lennox Island ☐ Own Health ☐ Other

**TOBACCO CESSATION ACTION PLAN**

<input type="checkbox"/> Reviewed Contraindications						
Long lasting NRT (Patch)	<input type="checkbox"/> 7 mg 7 mg x 6 wks	<input type="checkbox"/> 14 mg 14 mg x 6 wks 7 mg x 4 wks	<input type="checkbox"/> 21 mg 21 mg x 6 wks 14 mg x 4 wks 7 mg x 2 wks	<input type="checkbox"/> 28 mg 28mg (21mg + 7mg) x 6wks 21 mg x 4 wks 14 mg x 2 wks 7 mg x 2 wks	<input type="checkbox"/> 35 mg 35mg (21mg + 14mg) x 6wks 28mg (21mg + 7mg) x 4 wks 21 mg x 2 wks 14 mg x 2 wks 7 mg x 2 wks	<input type="checkbox"/> 42 mg 42 mg (21mg + 21mg) x 6 wks 35mg (21mg + 14mg) x 4 wks 28mg (21mg + 7mg) x 2 wks 21 mg x 2 wks 14 mg x 2 wks 7 mg x 2 wks
Short Acting NRT	<input type="checkbox"/> Inhaler	<input type="checkbox"/> Gum: 2mg <input type="checkbox"/> Gum: 4mg	<input type="checkbox"/> Lozenge: 1mg <input type="checkbox"/> Lozenge: 2mg <input type="checkbox"/> Lozenge: 4mg	<input type="checkbox"/> Spray: 1mg <input type="checkbox"/> Spray: 2mg		
Medication	<input type="checkbox"/> Varenicline <input type="checkbox"/> Bupropion <input type="checkbox"/> Reviewed appropriate use, dose, duration of medication				Notes: (free text)	

**VAPING CESSATION ACTION PLAN**

<input type="checkbox"/> Reviewed Contraindications						
Long lasting NRT (Patch)	<input type="checkbox"/> 7 mg 7 mg x 6 wks	<input type="checkbox"/> 14 mg 14 mg x 6 wks 7 mg x 4 wks	<input type="checkbox"/> 21 mg 21 mg x 6 wks 14 mg x 4 wks 7 mg x 2 wks	<input type="checkbox"/> 28 mg 28mg (21mg + 7mg) x 6 wks 21 mg x 4 wks 14 mg x 2 wks 7 mg x 2 wks	<input type="checkbox"/> 35 mg 35mg (21mg + 14mg) x 6 wks 28mg (21mg + 7mg) x 4 wks 21 mg x 2 wks 14 mg x 2 wks 7 mg x 2 wks	<input type="checkbox"/> 42 mg 42 mg (21mg + 21mg) x 6 wks 35mg (21mg + 14mg) x 4 wks 28mg (21mg + 7mg) x 2 wks 21 mg x 2 wks 14 mg x 2 wks 7 mg x 2 wks
Short Acting NRT	<input type="checkbox"/> Inhaler <input type="checkbox"/> Spray 1 mg	<input type="checkbox"/> Spray 2 mg <input type="checkbox"/> Gum 2mg	<input type="checkbox"/> Gum 4mg <input type="checkbox"/> Lozenge 1mg	<input type="checkbox"/> Lozenge 2mg <input type="checkbox"/> Lozenge 4mg		

Personal Health Information on this form is collected under Prince Edward Island's *Health Information Act*, as it relates to and is necessary for determining assessment of needs and eligibility for benefits under the PEI Pharmacare Program (Smoking Cessation Program). If you have any questions about this collection of Personal Health Information, you may contact the Provincial Tobacco Control Coordinator at 902-368-4319.

**PROVIDER INFORMATION**

Healthcare Provider Name:	Signature:
Telephone Number:	Date: yyyy-mm-dd

# Program Form: Follow-up

-Monitor progress; change NRT product/method before initial 30 days if required

-Recommend follow up at three intervals:

- 1-2 weeks;
- 1-2 months;
- End of treatment

Smoking Cessation Follow Up Consult Form	
<div><div><div>Health PEI One Island Health System Santé Î.-P.-É. Un système de santé unique</div><div>Fax form to the Smoking Cessation Program 902-569-0579</div></div><div>Date: <u>DD/MM/YY</u> Quit Date: <u>DD/MM/YY</u> <input type="checkbox"/> 3 days after quit date <input type="checkbox"/> 7 days after quit date <input type="checkbox"/> 14 days after quit date <input type="checkbox"/> 1 Month <input type="checkbox"/> 2 Months <input type="checkbox"/> 3 Months <input type="checkbox"/> 4 Months <input type="checkbox"/> 5 Months <input type="checkbox"/> 6 Months Patient PHN/MRN: _____ First Name: _____ Last Name: _____ Date of Birth: <u>DD/MM/YY</u></div></div>	
LOCATION: <input type="checkbox"/> Kings PC <input type="checkbox"/> Queens East PC <input type="checkbox"/> Queens West PC <input type="checkbox"/> East Prince PC <input type="checkbox"/> West Prince PC <input type="checkbox"/> PEI Cancer Treatment Centre <input type="checkbox"/> Cardiac and Pulmonary Rehab <input type="checkbox"/> Home Care <input type="checkbox"/> Lennox Island <input type="checkbox"/> Pharmacy	
<b>ASSESS SMOKING and VAPING STATUS</b>	
Have you used any form of tobacco products in the past 7 days?	<input type="checkbox"/> No <input type="checkbox"/> Yes Within 30 minutes of waking? <input type="checkbox"/> No <input type="checkbox"/> Yes cigs/day: _____ Reason Relapse: _____
Have you used any form of vaping products in the past 7 days?	<input type="checkbox"/> No <input type="checkbox"/> Yes Within 30 minutes of waking? <input type="checkbox"/> No <input type="checkbox"/> Yes mgs/day: _____ Reason Relapse: _____
<b>MEDICATIONS MANAGEMENT</b>	
Are you still using the quit smoking medications we recommended?	<input type="checkbox"/> No <input type="checkbox"/> Yes Type: _____
Do you have any questions or concerns about the medication?	<input type="checkbox"/> No <input type="checkbox"/> Yes Dose: _____
Are you still using the quit vaping medications we recommended?	<input type="checkbox"/> No <input type="checkbox"/> Yes Type: _____
Do you have any questions or concerns about the medication?	<input type="checkbox"/> No <input type="checkbox"/> Yes Dose: _____
<b>WITHDRAWAL &amp; SIDE EFFECTS</b>	<b>MOOD CHANGES</b>
Have you experienced any of the following symptoms? Rate Severity (Mild [0] – Severe [4])	Have you or your family/friends noticed any changes to your mood since quitting? Rate Severity (Mild [0] – Severe [4])
<input type="checkbox"/> nausea <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> headache <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> sleep disturbance <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> skin irritation <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> restlessness <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> difficulty concentrating <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> other: _____ <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> anger/hostility <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> anxiety <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> feeling depressed <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> other: _____ <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
CAFFEINE USE How many caffeinated beverages are your drinking per day?	<input type="checkbox"/> 0 <input type="checkbox"/> 1-2 <input type="checkbox"/> 2-4 <input type="checkbox"/> >4
CRAVING S Have you had any cravings to smoke?	<input type="checkbox"/> No <input type="checkbox"/> Yes
CRAVING S Have you had any cravings to vape?	<input type="checkbox"/> No <input type="checkbox"/> Yes
<b>RELAPSE RISK</b>	
Have there been any situations that made you feel like you were at risk for going back to smoking?	<input type="checkbox"/> No <input type="checkbox"/> Yes
From 1 – 10, with 10 being most confident, how confident are you that you can quit smoking or stay quit?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10
Have there been any situations that made you feel like you were at risk for going back to vaping?	<input type="checkbox"/> No <input type="checkbox"/> Yes
From 1 – 10, with 10 being most confident, how confident are you that you can quit vaping or stay quit?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10

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Last updated: 1 April 2023

QUIT SMOKING MEDICATION ADJUSTMENT *If making adjustment, new intake form is required			
<input type="checkbox"/> Nicotine Replacement Therapy (NRT)	<input type="checkbox"/> Patch Starting Dose: <input type="checkbox"/> 7 mg <input type="checkbox"/> 14 mg <input type="checkbox"/> 21 mg <input type="checkbox"/> 28 mg <input type="checkbox"/> 35 mg <input type="checkbox"/> 42 mg	<input type="checkbox"/> Inhaler <input type="checkbox"/> Gum ( <input type="checkbox"/> 2mg or <input type="checkbox"/> 4mg ) <input type="checkbox"/> Lozenge ( <input type="checkbox"/> 2mg or <input type="checkbox"/> 4mg ) <input type="checkbox"/> Mouth Spray	
<input type="checkbox"/> Short Acting NRT	<input type="checkbox"/> Inhaler <input type="checkbox"/> Gum ( <input type="checkbox"/> 2mg or <input type="checkbox"/> 4mg ) <input type="checkbox"/> Lozenge ( <input type="checkbox"/> 2mg or <input type="checkbox"/> 4mg ) <input type="checkbox"/> Mouth Spray <small>**NB: Dose and duration of NRT should be stratified based on patient's needs.</small> <small>For use on own or combined with patch (PRN). [Note: Patients are only covered for one method under the Smoking Cessation Drug Cost Assistance Program, and mouth spray is not currently covered under the program]</small>		
<input type="checkbox"/> Varenicline <input type="checkbox"/> Bupropion <input type="checkbox"/> Reviewed appropriate use, dose, duration of medication	<input type="checkbox"/> No medication		
Relapse Prevention Plan - Smoking			
Issue: _____		Plan: _____	
<b>QUIT VAPING MEDICATION ADJUSTMENT *If making adjustment, new intake form is required</b>			
Starting Dose:	Light Vape User (0-20mg per day): <input type="checkbox"/> 14 mg 14 mg x 6 wks. <input type="checkbox"/> Long lasting NRT (Patch) 7 mg x 4 wks.	Moderate Vape User (20-40mg per day): <input type="checkbox"/> 21 mg 21 mg x 6 wks. 14 mg x 4 wks. 7 mg x 2 wks.	Heavy Vape User (40mg+ per day): <input type="checkbox"/> 28 mg 28mg (21mg + 7mg) x 6 wks. 21 mg x 4 wks. 14 mg x 2 wks. 7 mg x 2 wks.
<input type="checkbox"/> Short Acting NRT	<input type="checkbox"/> Inhaler 1 cartridge every 30 minutes as needed	<input type="checkbox"/> Gum: 2mg <input type="checkbox"/> Nicorette® Lozenge: 2mg <input type="checkbox"/> Thrive® Lozenge: 1mg	<input type="checkbox"/> Gum: 4mg <input type="checkbox"/> Nicorette® Lozenge: 4mg <input type="checkbox"/> Thrive® Lozenge: 2mg
Relapse Prevention Plan - Vaping			
Issue: _____		Plan: _____	
Notes and Comments: _____			
Follow Up Plan _____ Weeks		Name of health care provider (signature) _____	

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Last updated: 1 April 2023

# PEI Smoking Cessation Program: Nicotine Replacement Therapy (NRT) Titration Schedule

Table 1: Patient Assessment Tool: NRT

NICOTINE PATCH	
<p><b>Patient smokes 40+ cigarettes per day:</b>            Nicotine Patch 42 mg (21 mg + 21 mg) daily x 6 weeks; then            Nicotine Patch 35 mg (21 mg + 14 mg) daily x 4 weeks; then            Nicotine Patch 28 mg (21 mg + 7 mg) daily x 2 weeks; then            Nicotine Patch 21 mg daily x 2 weeks; then            Nicotine Patch 14 mg daily x 2 weeks; then            Nicotine Patch 7 mg daily x 2 weeks</p> <p><b>Patient smokes 35-39 cigarettes per day:</b>            Nicotine Patch 35 mg (21 mg + 14 mg) daily x 6 weeks; then            Nicotine Patch 28 mg (21 mg + 7 mg) daily x 4 weeks; then            Nicotine Patch 21 mg daily x 2 weeks; then            Nicotine Patch 14 mg daily x 2 weeks; then            Nicotine Patch 7 mg daily x 2 weeks</p> <p><b>Patient smokes 30-34 cigarettes per day:</b>            Nicotine Patch 28 mg (21 mg + 7 mg) daily x 6 weeks; then            Nicotine Patch 21 mg daily x 4 weeks; then            Nicotine Patch 14 mg daily x 2 weeks; then            Nicotine Patch 7 mg daily x 2 weeks</p>	<p><b>Patient smokes 20-29 cigarettes per day:</b>            Nicotine Patch 21 mg daily x 6 weeks; then            Nicotine Patch 14 mg daily x 4 weeks; then            Nicotine Patch 7 mg daily x 2 weeks</p> <p><b>Patient smokes 10-19 cigarettes per day:</b>            Nicotine Patch 14 mg daily x 6 weeks; then            Nicotine Patch 7 mg daily x 4 weeks</p> <p><b>Patient smokes &lt;10 cigarettes per day:</b>            Nicotine Patch 7 mg daily x 6 weeks</p> <div style="border: 2px solid red; padding: 5px; margin-top: 10px;"> <p>If smokes within 30 minutes of waking, add 7 mg to initial start dose</p> </div>
NICOTINE GUM	
<p><b>Patient smokes 20+ cigarettes per day:</b>            Nicotine Gum 4 mg pieces</p> <p><b>Patient smokes &lt;20 cigarettes per day:</b>            Nicotine Gum 1 mg or 2 mg pieces</p>	
NICOTINE LOZENGES	
<p><b>Patient smokes 20+ cigarettes per day:</b>            Nicotine Lozenge 4 mg</p> <p><b>Patient smokes &lt;20 cigarettes per day:</b>            Nicotine Lozenge 2 mg</p>	
NICOTINE INHALER	
<p>Use 6-12 cartridges per day or as needed for the first 6 weeks.</p>	
NICOTINE SPRAY	
<p><b>Patient smokes 20+ cigarettes per day:</b>            Nicotine Spray 2mg</p> <p><b>Patient smokes &lt;20 cigarettes per day:</b>            Nicotine Spray 1mg</p>	

Table 2: Patient Assessment Tool: Vaping Cessation

PATIENT ASSESSMENT TOOL: VAPING CESSATION			
Profile	Dependence	Estimated Nicotine Consumed (mg)	Recommended Starting Dose (mg)
LONG ACTING (PATCH)			
Light Vape User (low dose)	<ul style="list-style-type: none"> <li>- Periodic use; Social use;</li> <li>- No cravings;</li> <li>- No withdrawal symptoms if going without vaping for 24 hours;</li> <li>- Nicotine concentration (e-liquid): &lt; 20mg</li> </ul>	0-20mg per day	14mg
Moderate Vape User	<ul style="list-style-type: none"> <li>- Stable use;</li> <li>- Cravings present;</li> <li>- Vape within 30 minutes of waking;</li> <li>- Few/mild withdrawal symptoms if going without vaping for 24 hours;</li> <li>- Nicotine concentration (e-liquid): &gt; 20mg</li> </ul>	20-40mg per day	21mg
Heavy Vape User (high dose)	<ul style="list-style-type: none"> <li>- Increasing use;</li> <li>- Intense cravings;</li> <li>- Vape within 30 minutes of waking;</li> <li>- Noticeable withdrawal symptoms if going without vaping for 24 hours;</li> <li>- Nicotine concentration (e-liquid): &gt; 20mg</li> </ul>	40mg+ per day	35mg
SHORT ACTING (GUM, LOZENGE, INHALER, SPRAY)			
Gum or lozenge: 2-4mg every 30 minutes as needed			
Inhaler: 1 cartridge every 30 minutes as needed			
Spray: 1mg: 1-2 sprays 1-24 times/day			
2mg: 1-2 sprays 1-32 times/day			

\*If unsure of light or heavy user choose 21mg (moderate vape user)

For program inquiries, please contact the Provincial Tobacco Control Coordinator at [quit-smoking@gov.pe.ca](mailto:quit-smoking@gov.pe.ca) or (902) 368-4319.



# Education/Training:

<https://www.youtube.com/watch?v=gZtZ20xr8M8>

Disclaimer: Not all comments made by the presenter represent current practice in PEI. Providers are expected to follow direction by the Smoking Cessation Program. In PEI, only one NRT method is covered 100% in the PEI Smoking Cessation Program.



# Frequently Asked Questions

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1. What NRT products are covered by the Smoking Cessation Program?
2. Can a patient/client receive more than one type of NRT while enrolled in the Smoking Cessation Program?
3. What if a patient/client relapses?
4. What if a program is interrupted and they don't complete it, are they able to enroll again?
5. What if the patient/client wants to change NRT product during the program?
6. What are common resources that patients/clients can access to support their smoking cessation journey?

# Smoking Cessation Resources

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- Smoker's Helpline: Support to anyone looking to quit smoking/vaping/other tobacco products
  - Call: 1-866-366-3667;
  - Visit: <https://smokershelpline.ca>
- Livewell PEI - Resources
  - Visit: [www.livewellpei.ca](http://www.livewellpei.ca)







**LIVE WELL PEI**  
*together we can*

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# Questions?

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**Contact Information for the Provincial Tobacco Control  
Coordinator:**

**Phone:** 902-368-4319

**Email:** [quitsmoking@gov.pe.ca](mailto:quitsmoking@gov.pe.ca)

**Web:** [www.princeedwardisland.ca/quitsmoking](http://www.princeedwardisland.ca/quitsmoking)