[Pharmacy Name]
[Street Address]
[City, State ZIP]
[Phone]
[Fax]
[Web address]

FAX

To:	**Address:**
Fax:	**City, State, Zip:**
Phone:	**Date:**
Re:	

Our mutual patient, ___________________________________, DOB: _____________ is ready to quit smoking and has enrolled in [Pharmacy Name]'s smoking cessation program. The program helps patients make a successful quit attempt by providing peer-led support groups facilitated by a pharmacist. Topics we cover include: overcoming addiction, coping with nicotine withdrawl, health benefits, and available nicotine cessation aids.

To help the patient be successful during their quit attempt, we are requesting a prescription nicotine cessation aid. The following page is an assessment and recommendation for your review. If the recommendation is agreeable to you, please fill in the information below and we will get the patient started.

If you have any questions, please contact me at the pharmacy. Thank you.

[Pharmacist Name] [Direct Line]

Medication / Strength	Directions for Use	Quantity

Prescriber Signature: ________________________________ Date:______________

NPI: _______________