Anthem HealthKeepers Plus
Offered by HealthKeepers, Inc.

Provider Bulletin
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Help your pregnant patients quit smoking

Please note, this communication applies to Anthem HealthKeepers Plus, Medallion and Anthem HealthKeepers Plus, Commonwealth Coordinated Care Plus (Anthem CCC Plus) offered by HealthKeepers, Inc.

Smoking is well-known to have negative health effects. Not only is it detrimental to the health of our members, but smoking also increases the risk of health issues in developing babies, including increasing the risk of preterm birth, low birth weight, miscarriage, fetal tissue damage in the lungs and brain, sudden infant death syndrome (SIDS), birth defects, and asthma or allergies in infants.[1] Quitting smoking during and after pregnancy can help ensure the health of the infant, as well as promote the health of our members.[2] As nicotine is highly addictive, it is important that mothers receive the support they need to quit smoking during pregnancy.

Available resources for members

There are a variety of resources available to connect individuals to counseling services. Providers can offer a direct referral to the National Tobacco Quit Line (**800-QUIT NOW**), which provides ongoing counseling and support covered by their MCO. If this service is not the right fit for your patient, there are other telephone based quit-smoking programs:

- American Heart Association:
  - **http://www.heart.org**
  - **800-242-8721**
- American Lung Association:
  - **www.lung.org**
  - **800-548-8252**
- American Cancer Society:
  - **www.cancer.org**
  - **800-227-2345**

Covered services

Nicotine replacement therapy						**Other medications**	
Preferred	**Non-Prescription**			**Prescription**			
	Nicotine Lozenge	Nicotine Patch	Nicotine Gum	n/a	n/a	Chantix®/Chantix® DS PK	Bupropion SR
Non-preferred (requires PA)	Nicorette® Lozenges	NicoDerm CQ Patch	Nicorette® Gum	Nicotrol Inhaler	Nicotrol Nasal Spray	Zyban®	

Figure 1. Covered Smoking Cessation Treatments
Note: Length of authorizations are six months. Routine *PDL*.

There are several approaches to helping your pregnant patients quit smoking. The first intervention recommended is to start with smoking cessation counseling, either individual or group. In accordance with the

1 https://www.cdc.gov/tobacco/basic_information/health_effects/pregnancy/index.htm
2 https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/Smoking_pregnancy/state/VA

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U.S. Preventive Services Task Force, these services are fully covered for Medallion 4.0 and CCC Plus members. Depending on the patient's needs, they may be eligible for different levels of services. We offer individual counseling visits, 3 to 10 minutes (99406), individual counseling visits > 10 minutes (99707), and unclassified group patient education (S9446). We cover six units per calendar year with no preauthorization.

For some high-risk patients, smoking cessation counseling is not enough, and it may be beneficial to pursue pharmacotherapy as an adjunct to counseling. Groups that may benefit from this service include pregnant women who would not otherwise be able to quit smoking without intervention, heavy smokers (> 10 cigarettes/day), individuals smoking later in pregnancy, and those who have been unsuccessful in their previous attempts to quit.[3] The second line of intervention, tobacco dependence treatment (for example, tobacco/smoking cessation) is covered at no cost to members. We provide coverage for smoking cessation in accordance with the ***SUPPORT Act*** requirements.

Pharmacotherapy

There are several principles for prescribing drugs during pregnancy. Firstly, to minimize fetal exposure, providers should prescribe the lowest dose necessary to achieve success. Despite concerns about underdosing due to the changes in pharmacokinetics during pregnancy, it is still best practice to start with the lowest dose. Secondly, to avoid embryogenesis, it is recommended that therapy is delayed until the second trimester as the fetus is most sensitive to teratogens before the second trimester. Both nicotine replacement therapy (NRT) and bupropion are sufficient treatment options for the general population, however the safety and efficacy of these drugs have not been directly compared in randomized trials with pregnant persons.[3] Please note that the optimal treatment is not known.

While many providers are reluctant to use NRT with pregnant patients, this may be a healthier alternative to smoking during pregnancy. Although the efficacy of NRT and fetal impact of treatment in pregnancy is not well established, the treatment does not appear to be harmful and may be associated with lower rates of premature birth. There is no strong evidence that pregnant smokers being treated with NRT are at a higher risk of adverse perinatal events than pregnant patients who smoke and are not using NRT. Even if NRT cannot eliminate all risk associated with smoking during pregnancy, engaging in maternal smoking cessation reduces the risk of fetal exposure in-utero to toxins that may contribute to poor pregnancy outcomes.[3]

Another treatment option is bupropion. Bupropion typically is used as an adjunct to counseling or for individuals with contraindications to NRT, patients who do not want to use NRT, or patients who have been unsuccessful with combined counseling and NRT. Bupropion should not be prescribed or taken while using NRT. Patients should be aware the bupropion crosses the placenta, but it should be noted that the data available on fetal impact is limited, inconsistent, and there are possibly confounding factors such as antidepressant use. No clear association with congenital malformations has been established, however a preventive option to consider is delaying the initiation of medication until after the first trimester ultrasound (11-14 weeks). The risk of miscarriage and birth defects after first trimester exposure to Bupropion were consistent with the general population rate. While there have been some cases of fetal heart defects in pregnant patients taking bupropion, the data is insufficient to evaluate the true risk. Patients also may consider waiting until the second trimester (18-20 weeks), once a more detailed anatomical ultrasound assessment can be conducted.[3]

Provider recommendations

It is important that the available data is discussed with patients to give them an opportunity to consider their options and what is best for their health and the health of their baby. Appropriate interventions are based on the patient's situation and willingness to quit. We encourage providers to use the five major steps to intervention,

3 https://www.uptodate.com/contents/tobacco-and-nicotine-use-in-pregnancy-cessation-strategies-and-treatment-options

the five As — ask, advise, assess, assist, and arrange, which have been adapted for use in smoking cessation during pregnancy.

The five As approach for delivering tobacco treatment interventions in maternal care settings

Step 1: ask

Ask the patient about their smoking status. Regardless of smoking status, providers should consider assessing exposure to secondhand smoke.

Action**:** Given high nondisclosure rates, identification of the pregnant smoker can be difficult. Specific strategies to identify smoking women include:

1. Use multiple choice questions when assessing whether a patient smokes. The following multiple-choice question is recommended in either oral or written form.
    a. Which of the following describes you best?
        i. I have **never** smoked, or I have smoked less than 100 cigarettes in my lifetime
        ii. I stopped smoking **before** I found out I was pregnant, and I am not smoking now.
        iii. I stopped smoking **after** I found out I was pregnant, and I am not smoking now.
        iv. I smoke some now, but I cut down on the number of cigarettes I smoke **since** I found out I was pregnant.
        v. I smoke regularly now, about the same as **before** I found out I was pregnant.
2. Focus particular attention on women who report that they stopped smoking after conception. About half of nondisclosers in one series reported quitting after conception.

Step 2: advise

Advise the patient with clear, strong advice for quitting smoking with personalized messages about the impact of smoking and quitting on mother and fetus.

Action:

1. Discuss the risks of smoking during pregnancy: low birth weight, placental abruption, placenta previa, premature delivery, stillbirth, and preterm premature rupture of membranes.
2. If the patient has had a history of a complicated pregnancy, discuss how smoking may have contributed to this complication.
3. Discuss risks of secondary smoke, particularly for patients with children at home, SIDS, upper respiratory infections, otitis media asthma, and pneumonia.
4. Recommend that the patient quit as soon as possible for maximal benefit; however, quitting at any time during pregnancy has some benefit.

Step 3: assess

Assess the willingness of the patient to make a quit attempt within the next month.

Action: Ask, *Quitting smoking is one of the most important things you can do for your health and the health of your baby. If we help you, are you willing to try?*

Step 4: assist

Assist smoker in quitting.

Action:

1. Provide pregnancy-specific, self-help smoking cessation materials; multi-lingual educational packets are available on the web at **http://www.modimes.org**.
2. Encourage the use of problem-solving methods and skills for cessation:
    a. Review withdrawal symptoms.

   b. Identify high-risk situations where they are more likely to relapse and set up strategies for avoiding them.
   c. Strongly consider referral to a social worker who can help patient gain access to services available to minimize stressors at home.
   d. Consider referral to coping and stress management program.
3. Encourage patient to seek family and social support:
   a. Identify nonsmoking individuals, particularly successful quitters that can be supportive.
   b. Offer referral to smoking partner for smoking cessation.
   c. Patient should inform family that they intend to quit smoking during the pregnancy and ask for their support (for example, not smoking in the same room).
4. Consider pharmacotherapy for patients who smoke 10 cigarettes or more and are unable to quit. Use lowest dose necessary:
   a. Bupropion
   b. NRT

Step 5: arrange

Arrange frequent follow up about smoking status throughout pregnancy and encourage cessation for continuing smokers.

Action:

1. Place a label on each chart that identifies the patient as a smoker.
2. Ask about smoking at each visit.
3. If the patient is still smoking, encourage cessation and consider adjunct pharmacotherapy as outlined.

If you have any questions about this communication, call Anthem HealthKeepers Plus, Medallion Provider Services at **800-901-0020** or Anthem CCC Plus Provider Services at **855-323-4687**.

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