Australian Capital Territory

Medicines, Poisons and Therapeutic Goods (Pharmacist Extended Scope of Practice – Minor Skin Conditions) Authorisation 2026 (No 1)

Notifiable instrument NI2026-188

made under the

Medicines, Poisons and Therapeutic Goods Regulation 2008, Section 490A, Authorisations for health practitioners to deal with medicines with CHO approval—Act, s 20 (1) (c)

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1 Name of instrument

This instrument is the Medicines, Poisons and Therapeutic Goods (Pharmacist Extended Scope of Practice – Minor Skin Conditions) Authorisation 2026 (No 1).

2 Commencement

This instrument commences the day after notification.

3 Authorisation

A pharmacist is authorised to supply a medicine or a class of medicines to a person without a prescription if the supply is performed in accordance with the ACT Pharmacist Extended Scope of Practice Minor Skin Conditions Authorisation set out in Schedule 1 of this document.

Dr Sally Singleton
Acting Chief Health Officer
10 April 2026

ACT Pharmacist Extended Scope of Practice Minor Skin Conditions Authorisation

Introduction

This Pharmacist Extended Scope of Practice Minor Skin Conditions Authorisation (Minor Skin Conditions Authorisation) is made under section 490A of the Medicines, Poisons and Therapeutic Goods Regulation 2008 for the purposes of establishing conditions and criteria under which a registered pharmacist may initiate the supply of the particular medicine or class of medicine to which the authorisation relates in the absence of a supply authority (prescription).

This Minor Skin Conditions Authorisation should be read in conjunction with the *Medicines, Poisons and Therapeutic Goods Act 2008*, the Medicines, Poisons and Therapeutic Goods Regulation 2008 (from www.legislation.act.gov.au) to ensure pharmacists are fully aware of their obligations when providing services.

Authorisation

A registered pharmacist[#] may deal with a medicine or a class of medicine to which the authorisation relates to under their own authority (without a prescription) to a person under the following conditions:

- The medicine is listed under Part A – Medicines Authorised under the relevant Section of this schedule;
- The patient is eligible under the patient eligibility criteria under Part B – Patient Eligibility under the relevant Section of this schedule;
- The pharmacist must follow the Patient Assessment Flowchart and Supplementary Information and Notes under Part C – Clinical Protocol under the relevant section of this schedule;
- The supply of the authorised medicine must fit within the requirements in Supply Limitations;
- The pharmacist must have completed the relevant requirements under Training Requirements;
- Both the patient and the pharmacist must both be physically present at a pharmacy that meets the listed requirements under Premises Standards;
- The pharmacist must follow the prescribed record keeping requirements under Record Keeping Requirements, including making a full clinical record, record storage requirements, sharing the clinical record with the patient's consent and reporting adverse effects; and
- Pharmacists must comply with Australian Health Practitioner Regulation Agency (Ahpra) and Pharmacy Board of Australia Code of Conduct, and the expected standards of ethical behaviour of pharmacists towards individuals, the community and society. Breaches will be dealt with in accordance with Governance and Complaints.

[#] *A Pharmacist is a person who holds registration under the Health Practitioner Regulation National Law (ACT), has completed the relevant training under Training Requirements, and is employed or engaged in a pharmacy that meets the requirements under Premises Standards.*

Supply Limitations

Pharmacists must only supply a medicine under this authorisation if all the following conditions are met:

- The pharmacist must only supply the restricted substance for the indication listed under the relevant Section, and only in the formulation and strength indicated,
- The pharmacist must not supply a medicine in a quantity that exceeds the duration of treatment listed under Part C – Clinical Protocol of the appropriate section, except:
    - If the smallest available size of the manufacturer's pack of the medicine exceeds the quantity specified in the Clinical Protocol, then the pharmacist may supply the medicine in the smallest available size.

Training Requirements

Pharmacists are considered to have appropriate training and competence to administer extended scope of practice services in the ACT, as outlined in this instrument, if they hold current registration with the Pharmacy Board of Australia under Ahpra, and have completed an Accredited clinical training course as described below:

- Pharmaceutical Society of Australia - Education on Dermatological Conditions, **OR**

- Australasian College of Pharmacy - Education on Dermatological Conditions, **OR**

- James Cook University's Extended Community Practice Pharmacists Course (subjects PC6100 and PC6200 only), **AND**
    - The Queensland University of Technology's Safe prescribing and quality use of medicines course, **OR**
    - James Cook University's Extended Community Practice Pharmacists Course (subject PC6300 only),

- Any other Accredited training recognised or required by the Chief Health Officer

Premises Standards

For a pharmacist to supply extended scope of practice services, the services must be provided in a pharmacy that meets the following requirements:

- Maintain up-to-date service availability listings on Health Direct;
- Has a consulting room consistent with the following:
    - is not to be used for any other purpose (such as a dispensary, storeroom, staff room or retail area),
    - is fully enclosed and provides adequate privacy for confidential conversations and any required examination (a divider or curtain in a dispensary, storeroom, staff room or retail area is not acceptable),
    - has adequate lighting,
    - is maintained at a comfortable ambient temperature,
    - has hand sanitisation facilities, and
    - has sufficient floor area, clear of equipment and furniture, to accommodate the applicable patient receiving the consultation and an accompanying person, and to allow the pharmacist adequate space to manoeuvre.

Record Keeping Requirements

After providing a service under this authorisation, pharmacists are required to complete a full clinical record of the consultation and should share a record of the consultation with the patient's usual treating medical practitioner, with the patient's consent.

Full Clinical Record

Pharmacists are required to make a full clinical record of the consultation using secure digital software. Records must be stored securely for a minimum of seven years and must contain:

- Sufficient information to identify the patient;
- The date of the consultation;
- The name of the pharmacist who undertook the consultation and their Healthcare Provider Identifier – Individual;
- Any information known to the pharmacist that is relevant to the patient's diagnosis or treatment (for example, information concerning the patient's medical history);
- Any clinical opinion reached by the pharmacist;
- Actions and management plan taken by the pharmacist;
- Particulars of any medication supplied for the patient (such as form, strength and amount);
- Notes or advice given to the patient in relation to any treatment proposed by the pharmacist who is treating the patient;
- Any consent given by a patient to the consultation, supply of medication and treatment proposed; and
- Any referrals made to a medical practitioner or other healthcare professional.

Storage Requirements

Records must be stored securely for a minimum of seven years, or in the case of health information collected while the patient was under 18 years – until the patient has attained the age of 25 years.

Sharing Clinical Record

The pharmacist must seek the patient's consent to share a record of the consultation and any subsequent consultations (including adverse events) with the patient's usual treating medical practitioner or medical practice, where the patient has one, following consent by the patient. If the patient **does** consent to the disclosure, the record must be shared within seven (7) days following the consultation.

Communication with the patient's usual treating medical practitioner or medical practice should ensure patient confidentiality is maintained. Use of a secure digital messaging platform is considered best practice.

Adverse Events

If a treating pharmacist becomes aware of an uncommon, unexpected or serious adverse event following treatment with an Approved Medicine, this must be reported to the Therapeutic Goods Association. This must be conducted via the usual processes, by reporting online at https://aems.tga.gov.au/

Governance and Complaints

The Health and Community Services Directorate (HCSD) takes an engage and educate approach to regulation including for activities under the *Medicines, Poisons and Therapeutic Goods Act 2008*. This approach focuses on providing education directly to community pharmacists choosing to offer extended scope of practice services to ensure they understand their roles and responsibilities. Pharmacists are expected to follow the Ahpra Code of Conduct.

Contravening any condition of this authorisation is grounds for disciplinary action under the *Medicines, Poisons and Therapeutic Goods Act* 2008, section 140 (Grounds for disciplinary action against authorisation holders). A contravention of Section 140 of the Act may result in disciplinary action under section 141 (Disciplinary action against authorisation holders).

Reports of unsafe practices, poor clinical practice or failure to adhere to the Code of Conduct may be reported to Ahpra and/or the ACT Health Services Commissioner.

Acknowledgement

HCSD acknowledges collaborative relationship with NSW Health with the following documents used with permission:

- NSW Pharmacist Practice Standards for Management of Impetigo
- NSW Pharmacist Practice Standards for Management of Herpes Zoster
- NSW Pharmacist Practice Standards for Management of Mild to Moderate Atopic Dermatitis
- NSW Pharmacist Practice Standards for Management of Mild Plaque Psoriasis

For further information about this authorisation please contact the Health Protection Service on 02 5124 9700 or at HPS@act.gov.au

Contents

Section 1 – Impetigo

Part 1. A – Medicines Authorised

The following listed medicines are authorised for the indication of the management of impetigo:

- mupirocin 2% ointment (excluding nasal ointment) or cream (topical)
- dicloxacillin (oral)
- flucloxacillin (oral)
- cefalexin (oral)
- trimethoprim and sulfamethoxazole (oral)

Part 1. B – Patient Eligibility

For Section 1, the management of impetigo, an eligible patient is aged 2 years or older.

Part 1. C – Clinical Protocol

For Section 1, the approved clinical protocol for the management of impetigo are in Appendix Part 1.C.

The Patient Assessment Flowchart should be used to assess the eligibility, identity, govern the supply of suitable treatments, and guide associated referral requirements. This flowchart should be read alongside the Supplementary Information and Notes.

Section 2 – Herpes Zoster

Part 2. A – Medicines Authorised

The following listed medicines are authorised for the indication of the management of herpes zoster:

- valaciclovir (oral)
- famciclovir (oral)
- aciclovir (oral)

Part 2. B – Patient Eligibility

For Section 2, the management of herpes zoster, an eligible patient is aged 18 years or older.

Part 2. C – Clinical Protocol

For Section 2, the approved clinical protocol for the management of Herpes Zoster are in Appendix Part 2.C.

The Patient Assessment Flowchart should be used to assess the eligibility, identity, govern the supply of suitable treatments, and guide associated referral requirements. This flowchart should be read alongside the Supplementary Information and Notes.

Section 3 – Mild to Moderate Atopic Dermatitis

Part 3.A – Medicines Authorised

The following listed medicines are authorised for the indication of the management of acute exacerbations of mild to moderate atopic dermatitis:

- methylprednisolone aceponate 0.1% ointment or fatty ointment
- triamcinolone acetonide 0.02% ointment
- mometasone furoate 0.1% ointment
- betamethasone dipropionate 0.05% ointment
- betamethasone valerate 0.1% ointment
- desonide 0.05% lotion
- pimecrolimus 1% cream
- crisborole 2% ointment

Part 3.B – Patient Eligibility

For Section 3, the management of acute exacerbations of mild to moderate atopic dermatitis, an eligible patient is aged between 2 and 65 years old (inclusive).

Part 3.C – Clinical Protocol

For Section 3, the approved clinical protocol for the management of acute exacerbations of mild to moderate atopic dermatitis are in Appendix Part 3.C.

The Patient Assessment Flowchart should be used to assess the eligibility, identity, govern the supply of suitable treatments, and guide associated referral requirements. This flowchart should be read alongside the Supplementary Information and Notes.

Section 4 – Mild Plaque Psoriasis

Part 4.A – Medicines Authorised

The following listed medicines are authorised for the indication of the management of acute exacerbations of mild plaque psoriasis:

- methylprednisolone aceponate 0.1% cream, ointment or fatty ointment
- mometasone furoate 0.1% cream, hydrogel or ointment
- betamethasone dipropionate 0.05% cream or ointment
- calcipotriol + betamethasone dipropionate 50 + 500 mcg/g ointment or foam

Part 4.B – Patient Eligibility

For Section 4, the management of acute exacerbations of mild plaque psoriasis, an eligible patient is aged 18 years or older.

Part 4.C – Clinical Protocol

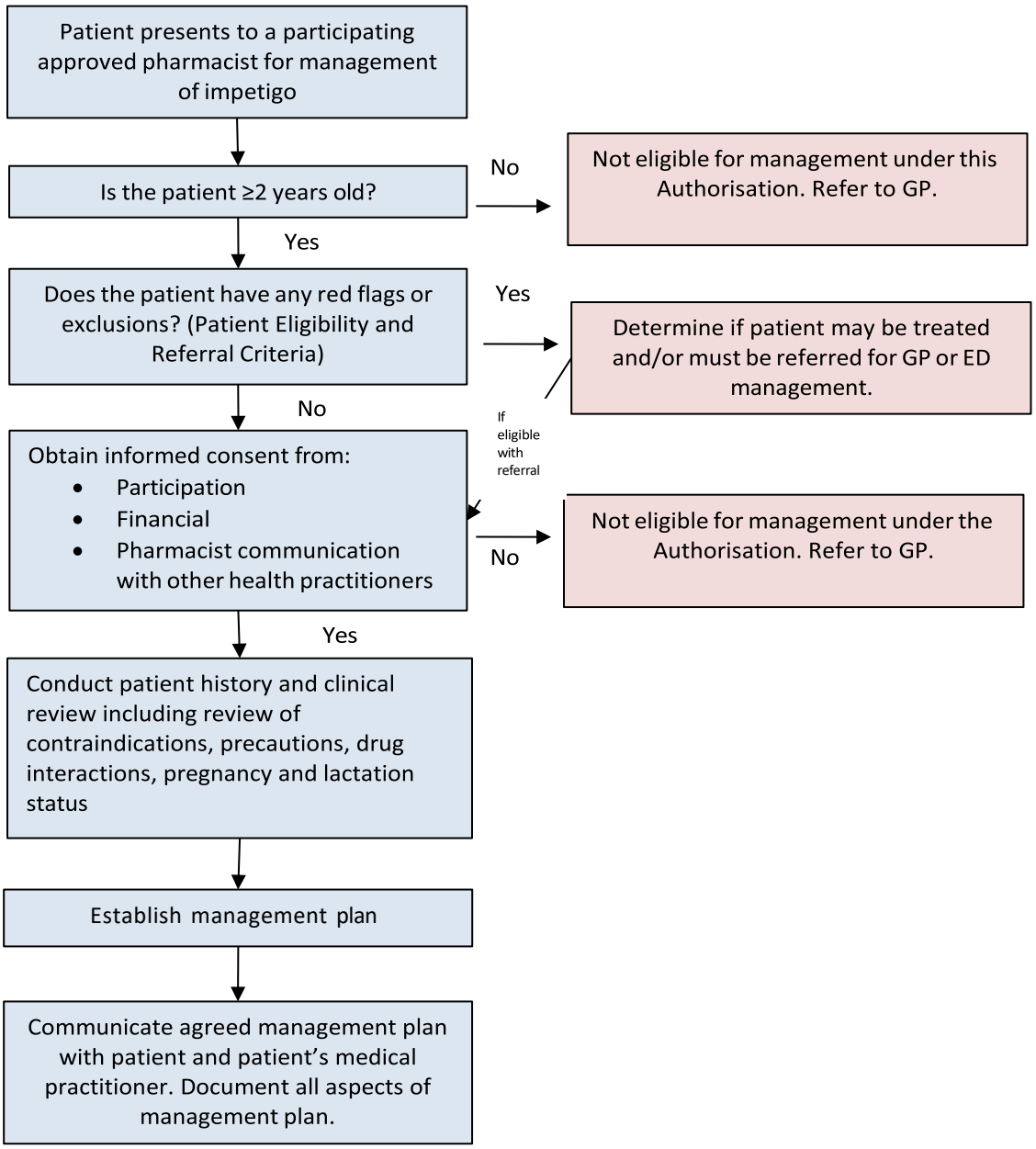
For Section 4, the approved clinical protocol for the management of acute exacerbations of mild plaque psoriasis are in Appendix Part 4.C.

The Patient Assessment Flowchart should be used to assess the eligibility, identity, govern the supply of suitable treatments, and guide associated referral requirements. This flowchart should be read alongside the Supplementary Information and Notes.

Appendix Part 1.C – Impetigo Clinical Protocol

Patient Assessment Flowchart

This clinical protocol has been adapted from the NSW Pharmacist Practice Standards for the treatment of Impetigo created by NSW Health and adapted for the ACT and used with permission.



Supplementary Information and Notes

This supplementary information provides guidance for pharmacists managing patients with impetigo under this Authority. It is to be used together with the training modules and other resources provided by education providers.

Key points

- To receive management for impetigo under this service, the patient must fulfil the eligibility requirements set out under Part D of Appendix A of this document. Patients who have requested the service but are not eligible for management should be referred to their regular medical practitioner or health service.
- Pharmacists can supply up to 5 days of therapy before referring a patient to a medical practitioner, or a higher quantity as specified in this Authorisation.
- Pharmacists must only supply formulations listed in this Authorisation.
- Patients must be physically present in the pharmacy to be eligible for management.
- Patients are required to have a consultation with an approved pharmacist before a medication can be supplied under the Authority.
- Pharmacists must make a full clinical record of the consultation and the details of all consultations and outcomes must be recorded using secure digital software. Records must be stored securely for minimum seven (7) years or, in the case of health information collected while the patient was under the age of 18 years, until the patient has attained the age of 25 years.
- Pharmacists must exercise professional discretion and judgement when applying the information within these Practice Standards. The Practice Standards do not override the responsibility of the pharmacist to make decisions appropriate to the circumstance of the individual, in consultation with their patient.

Patient Consent

The pharmacist must seek the patient's consent to share a record of the consultation and any subsequent consultations (including adverse events) with the patient's usual treating medical practitioner or medical practice, where the patient has one, following consent by the patient. If the patient **does** consent to the disclosure, the record must be shared within seven (7) days following the consultation.

Communication with the patient's usual treating medical practitioner or medical practice should ensure patient confidentiality is maintained. Use of a secure digital messaging platform is considered best practice.

Patient Eligibility and Referral Criteria

- Patients must be aged 2 years or older to be eligible for the service.
- Patients who meet any of the urgent referral criteria below must be referred to their regular medical practitioner, maternity provider, health service, or emergency department (ED) as indicated in the table.
- Pharmacists must not provide management to individuals specified in the table below, where there is a 'No' in the 'Treat' column for the patient group, and must take appropriate action in accordance with established referral pathways.
- Patients who require non-urgent referral to a GP or a healthcare provider are to be referred in accordance with the usual referral processes.

- Pharmacists must apply clinical judgement and refer any patient considered appropriate for medical care.
- Pharmacists must consult the Therapeutic Guidelines and other relevant references to confirm management is appropriate, including for:
    - Contraindications and precautions
    - Drug interactions
    - Pregnancy and lactation

	Referral criteria	Treat	Referral
'Red flag' warning signs	Severe or widespread or painful rash	No	Urgent: ED
	Raised purple rash that doesn't blanch	No	Urgent: ED
	Generalised erythema that covers 90% or more of the skin surface	No	Urgent: ED
	Signs of sepsis, systemic illness or other complications including Acute Poststreptococcal Glomerulonephritis (APSGN) and Acute Rheumatic Fever (ARF) such as: fever, confusion, lethargy, tachycardia, hypotension, hypertension, clammy skin, rash, nausea, vomiting, diarrhoea, facial or peripheral oedema, headache, joint pain and/or swollen joints	No	Urgent: ED
	Blistering of the skin and mucous membranes (including mouth and eyes)	No	Urgent: ED
	Bullous lesions and/or ecthyma	No	Urgent: ED
	Cellulitis, gangrene and/or bacteraemia	No	Urgent: ED
	Lymphadenopathy or lymphadenitis	No	Urgent: ED or GP
	Chronic sores or ulcers	No	Urgent: ED or GP
	Symptoms not resolved or worsened after treatment (within 5 days)	No	Urgent: ED or GP
	Severe disease	No	Urgent: ED or GP
	Immunocompromised patients • due to underlying medical condition (e.g. transplant recipients, patients with malignancies, patients receiving chemotherapy, HIV infection, uncontrolled diabetes, advanced age) • due to medication taken by the patient (such as immunomodulatory therapy, prednisone therapy)	No	Urgent: ED or GP
	Paediatric patient requiring oral antibiotics (*pharmacists can only manage mild presentations of impetigo. All moderate to severe presentations require referral to a medical practitioner. Oral antibiotics in paediatric cases are indicated for severe presentations only.)	No	GP
	Patients aged 65 years and older (**patients in this age range must be simultaneously referred to a medical practitioner and cannot receive multiple consultation without confirming they have also received medical practitioner follow-up)	Yes	GP
Details of presenting complaint	The patient is below 2 years of age	No	GP
	The diagnosis is unclear	No	GP
	Vesicles in more than one location	No	GP
	Symptoms have not resolved after the first course of antibiotic treatment, or symptoms worsen	No	GP
	Recurrent impetigo (defined as 2 or more presentations in the same year in an adult, and more than 1 presentation in the same year in a child)	No	GP
	Patient requires swabbing and further investigations or decolonisation	No	GP
	The patient has an underlying medical condition or a suspected co-occurring condition that may lead to complications (e.g. viral infection, eczema herpeticum/herpes simplex, contact dermatitis, atopic dermatitis, scabies)	No	GP

	Referral criteria	Treat	Referral
	Food and/or drinking aversion in children	No	GP
	The patient is currently, or has recently resided in a community where impetigo is endemic, such as refugees or migrants from low-middle income countries, rural and remote communities (refer to table "Individuals at high risk of developing ARF")	No	GP

Background

- Impetigo is a common bacterial skin infection caused by *Staphylococcus aureus* and *Streptococcus pyogenes*. It is also called 'school sores'. It mostly affects pre-school and primary school-aged children; however, people of all ages can get impetigo.
- Impetigo is very contagious and is usually transmitted through skin-to-skin contact but can also be transmitted by touching surfaces or objects that have been contaminated, including clothing, towels and bedding.
- Impetigo causes sores on the skin that often start as a red area which develops into small blisters that join together and eventually break down leaving thick oozing crusts with a characteristic golden yellow honey-colour.
- Impetigo may have similar presentations to and often co-occurs with other common skin conditions including contact dermatitis, thermal burns, folliculitis, dermatophytosis, candidiasis, eczema, scabies, herpes zoster, atopic dermatitis, varicella, herpes simplex virus (HSV) and molluscum contagiosum. Bullous impetigo has important differentials in paediatrics including linear IgA, contact dermatitis, bullous insect bite reaction and mastocytomas. Pharmacists need to be alert to the complex nature of presentations of impetigo and any suspicions of co-occurring or underlying conditions or atypical presentations must be referred to a medical practitioner. Be aware of cognitive bias, focus on excluding red flags and early referral to a medical practitioner.
- Red flag symptoms (listed in the table above) are suggestive of other serious conditions and require immediate referral to a medical practitioner for assessment.
- Impetigo can lead to more serious illnesses such as sepsis, ARF, rheumatic heart disease and APSGN. Caution must be exercised by pharmacists managing patients with suspected complex presentations of sepsis, ARF, rheumatic heart disease and APSGN. Pharmacists are required to immediately refer these patients to an emergency department for urgent medical assessment.
- Impetigo is mistaken for herpes simplex virus (HSV) and vice versa. Recurrent HSV could occur in any sexually active person rather than recent sexual risk.
- The infection usually occurs in hot humid conditions, and crowded living conditions. Risk factors include poor personal hygiene, an unhygienic work environment, poverty, underlying scabies, a low or poorly functioning immune system.
- Some populations, such as people of Aboriginal and Torres Strait Islander descent, are at high risk of complications with impetigo. See table "Individuals at high risk of developing ARF" for more details.
- In nonendemic settings (nonremote communities), impetigo is most commonly caused by *Staphylococcus aureus (S. aureus)*, and less commonly by *Streptococcus pyogenes* (group A streptococcus; *S. pyogenes*). Infection may also be caused by both *S. aureus* and *S. pyogenes*.
- In endemic settings, such as remote communities in central and northern Australia, impetigo is typically caused by *S. pyogenes*, even if *S. aureus* is identified by culture (including community-associated methicillin-resistant *S. aureus* [CA-MRSA]).
- MRSA is a common cause of recurrent infection, and non-responders to therapy are often infected with MRSA. These situations require referral to a medical practitioner for further investigations and management.

- Recurrent impetigo is defined as 2 or more presentations in the same year in an adult, and more than 1 presentation in the same year in a child. Recurrent impetigo presentations require referral to a medical practitioner for investigations (swabs) and management, especially if recurrence occurs in a short time (within months). Recurrent infections are a red flag for underlying immunodeficiency and requires urgent investigation.
- Antibacterial washes, staphylococcal carriage identification and decolonisation are important in recurrent presentations.
- Impetigo can be classified into primary or secondary categories:
    - Primary impetigo: a direct bacterial infection of otherwise healthy skin
    - Secondary impetigo: is the most common, a bacterial infection of a break in the skin from a trauma or pruritic conditions. The occurrence of secondary impetigo is referred to as impetiginisation.
- Clinical presentations of impetigo include:

Clinical presentations of impetigo	
Type	**Description**
Non-bullous	• Characterised by thin-walled papules that progress to vesicles surrounded by erythema. They may be itchy, usually not painful. They become pustules and enlarge and rapidly break down to form characteristic golden/honey-coloured crusts. • May start with a single vesicle that coalesces with others; often self-inoculation leads to multiple lesions, particularly on the face and extremities (although any body part can be affected). • Patients are generally otherwise well, although they may have regional lymphadenopathy. • Lesions may resolve spontaneously within 2-4 weeks without treatment and heal without scarring.
Bullous	• Presents as irritating, larger (diameter often >1cm) fluid-filled vesicles and blisters that rupture quickly to broad-based bullae, and progress to a thin, flat yellow/brown crust. • Tends to occur in moist intertriginous areas including nappy area, axillae and neck, as well as the face, trunk and extremities. • Lesions typically have scaling on the border of the bullae (collarette). • Patients with bullous impetigo are more likely to experience systemic symptoms including fever, malaise, and lymphadenopathy. • Lesions may resolve spontaneously within 2-4 weeks without treatment and heal without scarring.
Ecthyma	• Is an ulcerative form of impetigo in which the lesions extend through the epidermis and deep into the dermis. • Characterised by crusted sores with underlying ulcers (“punched out” ulcers) • If the crust is removed, an indurated ulcer will appear red, swollen and oozing. • Most commonly affects the buttocks, thighs, legs, ankles and feet. • People more likely to develop ecthyma include children, immunocompromised people, people with untreated impetigo and people living in crowded condition with poor hygiene. • Lymphadenopathy may occur. • Lesions resolve slowly and sometimes spontaneously without treatment although they may gradually enlarge and also scar. • Patients with ecthyma need to be referred to a medical practitioner.

Investigations (swabs)

- Patients with mild impetigo do not require an initial skin swab before empirical antibiotic therapy is started but should have a swab taken for culture and susceptibility testing if there

is no response to empirical therapy. In this instance, a pharmacist must refer to a medical practitioner.

- Patients presenting with more severe disease require a skin swab for culture and susceptibility testing before empirical antibiotic therapy is started. Pharmacists must refer all presentations of severe disease for urgent medical practitioner review without commencing any therapy.

Complications of impetigo

- Complications of impetigo, particularly bullous and ecthyma clinical presentations include:
    - Lymphangitis, lymphadenitis
    - Widespread infection, cellulitis, gangrene, bacteraemia
    - Permanent scarring
- Complications arising from Group A Streptococcal infections (more likely within endemic settings) include:
    - APSGN and chronic kidney disease
    - ARF
    - Sepsis
    - Osteomyelitis
- Acute Poststreptococcal Glomerulonephritis (APSGN)
    - APSGN is an immune-mediated sequalae of nephrotic strains of *S. pyogenes*
    - May occur approximately 2 to 3 weeks after a skin or throat infection of group A streptococcus bacteria
    - May affect any age but most commonly affects children between 12 months and 17 years
    - Common symptoms and clinical features include obvious facial and orbital swelling, particularly on waking, hypertension, fever, proteinuria and macroscopic haematuria with dark brown urine, and lethargy, weakness and/or anorexia.
- Acute Rheumatic Fever (ARF)
    - ARF is an immune-mediated sequalae of *S. pyogenes* involving multiple system organs, including the heart, joints, and central nervous system
    - May occur between 1 and 5 weeks post-streptococcal infection, and is most common after recurrent streptococcal infections, particularly pharyngitis and impetigo
    - Most frequently affects children aged between 5 and 14 years
    - Common symptoms and clinical features include sore and/or swollen joints, fever, increase resting heart rate, facial or peripheral oedema, Sydenham chorea
    - People at high risk of developing ARF are specified in the table below.

Individuals at high risk of developing ARF
Individuals aged 40 years and under
• Aboriginal and Torres Strait Islander people residing in a rural or remote area, or living in a household affected by household overcrowding (>2 people per bedroom) or of lower socioeconomic status • Māori and/or Pacific Islander person living in a household affected by household overcrowding or socioeconomic disadvantage • People with a recent personal or family/household history of ARF or rheumatic heart disease (RHD)
Additional risk factors for individuals aged ≤40 years (particularly 5 to 20 years)
• People living in a house affected by household overcrowding (>2 people per bedroom) or of socioeconomic disadvantage • People with current or recent residence (including frequent or recent travel to) in an area with a high rate of ARF (Australia or internationally) e.g. refugees and migrants from lower-middle income countries, rural and remote communities

Patient Assessment

A patient history and examination that is tailored to the patient's presentation is required to inform the management approach, including appropriate referral. The prompts provided below are not exhaustive, pharmacists should maintain an open mind and be aware of cognitive bias.

PATIENT HISTORY

Sufficient information must be obtained from the patient to assess the safety and appropriateness of management. The My Health Record should be reviewed where appropriate and available.

The patient history should include:

- Age
- Weight (if presenting patient is a child)
- Pregnancy and lactation status (if applicable)
- Ethnicity (Aboriginal and Torres Strait Islander, Māori or Pacific Islander)
- Most recent place of residence/community and/or recent travel to a place where impetigo or ARF may be endemic (a high rate of ARF within the population)
- Onset, duration, nature, location, and extent of lesions
- Recent skin and throat infections and treatment received
- Other signs and symptoms e.g. pain, lymphadenopathy, signs of sepsis or other complications including APSGN and ARF such as fever, confusion, tachycardia, hypotension, hypertension, clammy skin, vomiting and diarrhea, facial or peripheral oedema, severe headache, joint pain and/or swollen joints
- Potential source of infection e.g. skin trauma, contact with people with similar symptoms
- Underlying medical conditions including skin conditions or immunosuppression that may lead to complications (e.g. atopic dermatitis, scabies, herpes simplex)
- Current and recently commenced medications (including prescribed medicines, vitamins, herbs, other supplements, and over-the-counter medicines)
- Drug allergies/adverse drug events (including risk of allergic reactions to antibiotics such as sulphur allergy for trimethoprim)
- Other risk factors: poor hygiene, daycare settings, crowding, malnutrition.

EXAMINATION

- Assessment of vital signs
- Physical examination of patient to assess rash

Management and Treatment Plan

- Patients with impetigo require antibiotic treatment.
- Patients with mild impetigo do not require an initial skin swab before empirical antibiotic therapy is started, but should have a swab taken for culture and susceptibility testing if there is no response to empirical therapy.
- Patients with more severe disease require a skin swab for culture and susceptibility testing before empirical antibiotic therapy is started.
- Topical antibiotics are considered sufficient treatment for most patients where small areas of skin are affected. However, topical antibiotics are not appropriate if the infection is widespread, or multiple family/community members are affected, due to the risk of rapid antibiotic resistance.
- Oral antibiotics are needed if large areas of skin are involved or if there are multiple patches.

- Pharmacists can only treat mild presentations of impetigo in paediatric patients. Any paediatric patient requiring oral antibiotics requires a referral to a GP (with no initiation of antibiotic treatment by the pharmacist). If oral antibiotics are indicated in a paediatric patient, the patient should be offered cefalexin liquid formulation in the first instance due to better tolerance than dicloxacillin or flucloxacillin.
- Patients aged 65 years and older can continue to be managed by a pharmacist but must be simultaneously referred for follow-up by a medical practitioner. Patients in this age range cannot receive multiple consultations for this condition without confirming they have also received medical practitioner follow-up.
- Use of benzathine benzylpenicillin is excluded from the scope of practice, and requires referral to a medical practitioner.
- The correct use of antibiotics is essential. Incorrect use or extended use of antibiotics increases the risk of antimicrobial resistance.
- Pharmacists may not supply combinations of antibiotics, corticosteroid creams, antivirals, antifungals all at once to a patient.
- Discussing the treatment regimen with patients and parent/caregiver reduces the risk that antibiotics will be used incorrectly. Where the patient or caregiver's ability/motivation to correctly use topical treatment is in doubt (e.g. where there are multiple sores) a referral to a medical practitioner should be organised.
- Pharmacist management of impetigo involves:
    - General and preventive measures
    - Treatment of co-occurring skin conditions with standard pharmacist care or referral to a medical practitioner
    - Pharmacotherapy as per the Therapeutic Guidelines: Impetigo
- Comprehensive advice and counselling (including supporting written information when required) as per the Therapeutic Guidelines, the Australian Medicines Handbook and other relevant resources, should be provided to the patient regarding:
    - Individual product and medicine use (dosing and duration)
    - Non-pharmacological, general, and preventative measures
    - How to manage adverse effects of treatment
    - When/how to seek further care and/or treatment from a medical practitioner
    - Recognising complications of impetigo, particularly ARF and APSGN

Follow-up care and review

- Clinical review with the pharmacist is generally not required.
- If the condition does not improve or resolve, or worsens (within 5 days), the patient should be advised to see a medical practitioner for further management.

Clinical Documentation and Communication

- The pharmacist must make an electronic clinical record, and a record in a pharmacy dispensing system regarding the supply of any medications under these services, in accordance with the Authority.
- Where a patient has a My Health Record, the pharmacist must ensure the details of the supply are uploaded to My Health Record, unless requested otherwise by the patient.

Resources

Patient information/resources:

- It is the pharmacist's responsibility to ensure the suitability and accuracy of any resources provided to patients.
- NSW Health factsheets: Impetigo

- The Royal Children's Hospital Melbourne: Kids Health Info Fact sheets: Impetigo
- Healthdirect factsheet: Impetigo
- UpToDate: Patient education: Impetigo (The Basics)
- UpToDate: Patient education: Impetigo (Beyond the Basics)
- American Academy of Dermatology: 10 tips to prevent spreading impetigo, and avoid getting it again

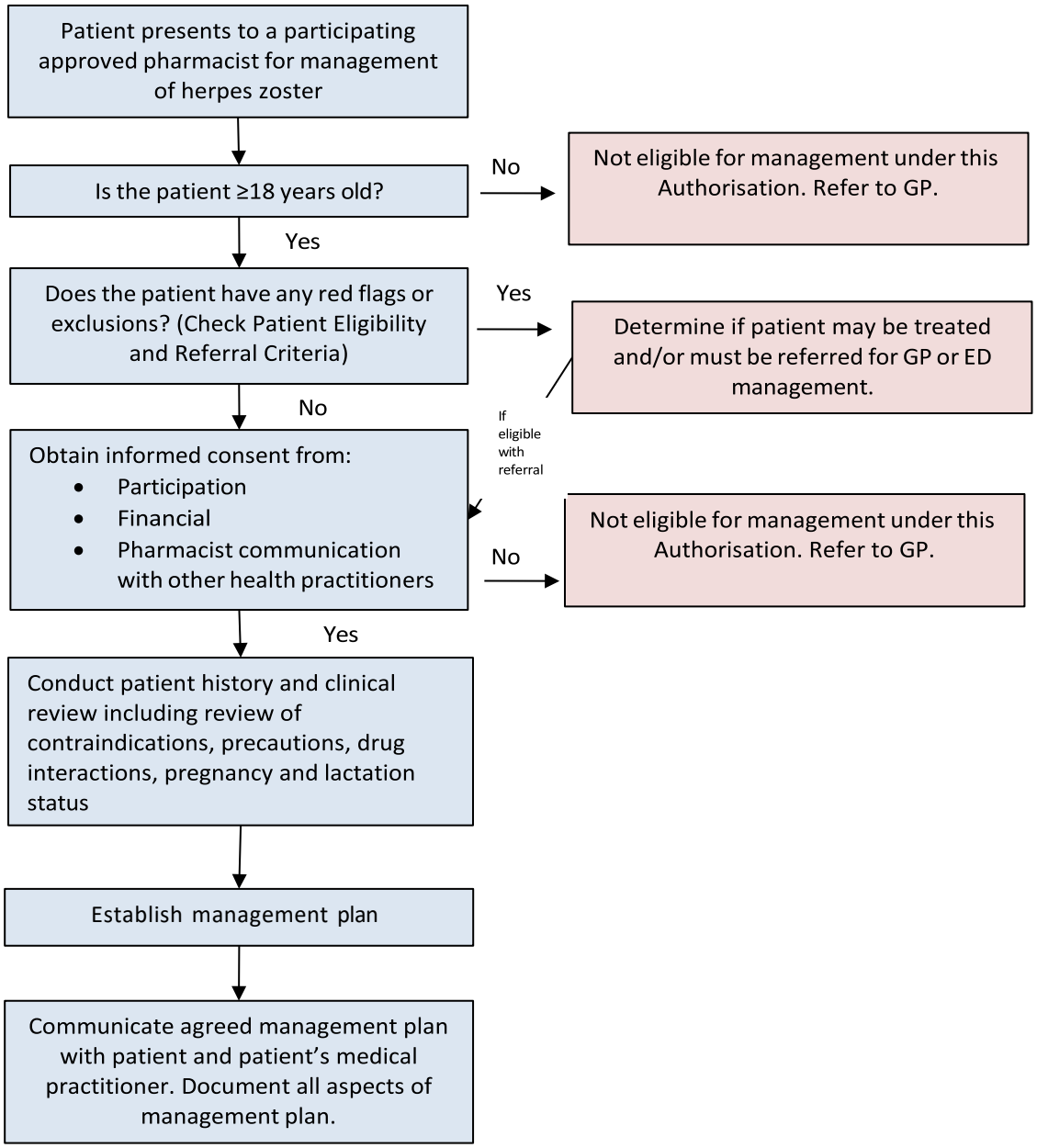
Pharmacist resources:

- Therapeutic Guidelines: Antibiotic: Impetigo
- Australian Medicines Handbook
    - Antibacterials (skin)
    - Antibacterials
- DermNet NZ:
    - Impetigo
    - Ecthyma
- MSD Manual (professional version): Impetigo and Ecthyma
- Australian Family Physician: Managing skin infections in Aboriginal and Torres Strait Islander children
- The Healthy Skin & ARF Prevention Team: Recognising & Treating Skin Infections: A visual clinical handbook
- National Healthy Skin Guideline For the Diagnosis, Treatment and Prevention of Skin Infections for Aboriginal & Torres Strait Islander Children and Communities in Australia
- Rheumatic Heart Disease Australia: ARF RHD Guideline and risk calculator (clinical support app)

Appendix Part 2.C – Herpes Zoster Clinical Protocol

Patient Assessment Flowchart

This clinical protocol has been adapted from the NSW Pharmacist Practice Standards for the treatment of Herpes Zoster created by NSW Health and adapted for the ACT and used with permission.



Supplementary Information and Notes

This supplementary information provides guidance for pharmacists managing patients with herpes zoster under this Authority. It is to be used together with the training modules and other resources provided by education providers.

Key points

- To receive management for herpes zoster under this service, the patient must fulfil the eligibility requirements set out under Part D of Appendix B of this document. Patients who have requested the service but are not eligible for management should be referred to their regular medical practitioner or health service.
- Pharmacists can supply up to 10 days of oral therapy before referring a patient to a medical practitioner, or a higher quantity as specified in this Authority.
- Pharmacists must only supply formulations listed in this Authority.
- Patients must be physically present in the pharmacy to be eligible for management.
- Patients are required to have a consultation with an approved pharmacist before a medication can be supplied under the Authority.
- Pharmacists must make a full clinical record of the consultation and the details of all consultations and outcomes must be recorded using secure digital software. Records must be stored securely for minimum seven (7) years.
- Pharmacists must exercise professional discretion and judgement when applying the information within these Practice Standards. The Practice Standards do not override the responsibility of the pharmacist to make decisions appropriate to the circumstance of the individual, in consultation with their patient.

Patient Consent

The pharmacist must seek the patient's consent to share a record of the consultation and any subsequent consultations (including adverse events) with the patient's usual treating medical practitioner or medical practice, where the patient has one, following consent by the patient. If the patient **does** consent to the disclosure, the record must be shared within seven (7) days following the consultation.

Communication with the patient's usual treating medical practitioner or medical practice should ensure patient confidentiality is maintained. Use of a secure digital messaging platform is considered best practice.

Patient Eligibility and Referral Criteria

- Patients must be aged 18 years or older to be eligible for the service.
- Patients who meet any of the urgent referral criteria below must be referred to their regular medical practitioner, maternity provider, health service, or Emergency Department (ED) as indicated in the table. Note that these are not exhaustive lists.
- Pharmacists must not provide management to individuals specified in the table below, where there is a 'No' in the 'Treat' column for the patient group, and must take appropriate action in accordance with established referral pathways.
- Patients must apply clinical judgement and refer any patient considered appropriate for medical care.
- Pharmacists must consult the Therapeutic Guidelines and other relevant references to confirm management is appropriate, including for:
    - Contraindications and Precautions
    - Drug Interactions
    - Pregnancy and Lactation

	Referral criteria	Treat	Referral
'Red flag' warning signs	Pregnancy	No	Urgent: ED* *Pharmacist to phone ED with notice of urgent medical referral. Patient must be advised not to attend a maternity or antenatal ward/appointment while symptoms are present.
	The patient does not respond to one course of optimal therapy or condition worsens	No	Urgent: ED
	Diagnosis is uncertain	No	Urgent: ED
	Antiviral treatment is indicated but the patient is allergic to valaciclovir, aciclovir and/or famciclovir	No	Urgent: ED
	The patient is aged under 18 years of age	No	Urgent: GP
	Immunocompromised patients • due to underlying medical condition (e.g. transplant recipients, patients with malignancies, patients receiving chemotherapy, HIV infection, uncontrolled diabetes, advanced age) • due to medication taken by the patient (such as immunomodulatory therapy, prednisone therapy)	Yes	Urgent: ED or GP
	Multi-dermatomal rash	Yes	Urgent: ED
	Disseminated zoster • suggested by: >2 contiguous dermatomes, bilateral involvement (lesions crossing the midline), involvement of non-contiguous dermatomes, visceral involvement	Yes	Urgent: ED
	Atypical cutaneous presentation	Yes	Urgent: ED
	Herpes zoster affecting the face, eyes, genitals • Herpes zoster ophthalmicus is suggested by: tearing, ocular pain, blurred vision, conjunctival infection, swelling/erythema of the lid and periorbital structures, uveitis, episcleritis, keratitis, vesicles on the nose, ear pain, taste loss, facial weakness or paralysis • Acute retinal necrosis is suggested by: blurred vision, rapid loss of vision, acute iridocyclitis, necrotising retinitis, pain	Yes	Urgent: ED or eye hospital (for suspicions of herpes zoster ophthalmicus or acute retinal necrosis)
	Complications of herpes zoster (such as): • postherpetic neuralgia [PHN], • specific zoster syndromes • neurological dysfunction (including presentations of confusion) • superinfection of shingles skin lesions	Yes	Urgent: ED
	Previous vaccination for herpes zoster	Yes	Urgent: GP
	Neuropathic shingle pain or moderate-to-severe nociceptive pain	Yes	Urgent: GP

Background

- Herpes zoster is a localised, blistering and painful rash caused by reactivation of varicella-zoster virus (VZV). Herpes zoster is also known as shingles.
- Anyone who has previously been infected with a VZV at any age can develop herpes zoster.
- The risk of developing herpes zoster increases with age, in someone with a weakened immune system, and in those who had chickenpox in the first year of their life.

- Early identification and management with antivirals (within 72 hours of the onset of rash) and analgesia reduces acute pain, rash duration, viral shedding and potential for ocular complications of herpes zoster.
- Vaccination is the most effective prevention for herpes zoster and its complications. The National Immunisation Program (NIP) recommends herpes zoster vaccination for patients at risk.
- Typical presentations of herpes zoster can be diagnosed based on patient history and examination for the characteristic appearance and distribution of the rash. The clinical presentation will vary depending on the patient's age, general health and affected dermatome.
- The incubation of VZV ranges from 10 to 21 days.
- Skin lesions usually heal within 2 to 4 weeks, although this may take longer particularly for those that are immunocompromised or those with severe disease. As the rash resolves, the pain and systemic symptoms also subside with recovery complete in 2 to 4 weeks in most cases.
- Herpes zoster is commonly mistaken for herpes simplex virus (HSV) and vice versa. Recurrent HSV could occur in any sexually active person rather than recent sexual risk.

PRESENTING SIGNS AND SYMPTOMS

Prodromal symptoms

- These may be observed between 48-72 hours before the localised, characteristic vesicular rash becomes evident. They include (but are not limited to):
    - Localised nerve pain (usually described as stabbing, prickling, throbbing or burning; known as acute neuritis)
    - Lethargy, fever, headache
    - Abnormal skin sensations such as burning, itching, hyperesthesia and/or paraesthesia
    - Photophobia (approximately 80% of cases).

Rash

- If the rash has presented for more than 72 hours, antiviral therapy is not recommended and will usually self-resolve in low-risk patients
- Typically, the herpes zoster rash is unilateral with a dermatomal distribution and distinct anterior and posterior midline cut-offs (satellite lesions may also appear)
- The rash develops with blisters or macules on an erythematous base. New lesions continue to erupt for 3 to 5 days following the nerve line, becoming pustular, before scabbing and crusting over between 7 to 10 days
- The most commonly affected areas are the chest, neck, forehead (ophthalmic) and lumbar/sacral sensory nerve supply regions
- When the ophthalmic division of the trigeminal cranial nerve is affected (herpes zoster ophthalmicus), the patient will present with a blistering rash around the eye/eyelid with associated pain, swelling and redness. Vesicles on the nose have been found to be predictive of eye involvement (Hutchinson sign) and suggest herpes zoster ophthalmicus. The condition is considered an ophthalmologic emergency due to the risk of vision loss if not quickly identified and treated early in the disease course. Pharmacists are required to immediately refer these patients to an emergency department or eye hospital for urgent medical assessment.
- If the facial nerve is affected (herpes zoster oticus/Ramsay Hunt Syndrome) symptoms will include earache, blistering in and around the ear canal, with or without external ear and facial paralysis.

Complications of herpes zoster

- Complications occur in approximately 13 to 26% of patients with herpes zoster and are most prevalent in older people and those who are immunocompromised. Caution must be exercised by pharmacists managing patients with suspected complex presentations and complications of herpes zoster. Pharmacists are required to immediately refer these patients for urgent medical assessment at presentation or at any stage if a complication develops.

Postherpetic neuralgia (PHN)

- The most common complication of herpes zoster is PHN.
- Defined as neuropathic pain that persists for at least 90 days after the onset of the rash or re-occurs; sharp/shooting and intermittent, described as constant burning, often with extreme sensitivity to touch (allodynia). These patients require referral to a medical practitioner for review and management of pain.

Herpes zoster ophthalmicus

- Herpes zoster affecting the ophthalmic branch of the trigeminal nerve with a high incidence of eye complications, occurring in 10-25% of the cases and commonly causes keratitis as well as conjunctivitis, uveitis, retinitis and glaucoma.
- Suggested by: tearing, ocular pain, blurred vision, conjunctival infection, swelling/erythema of the lid and periorbital structures, uveitis, episcleritis, keratitis.
- Vesicles on the nose have been found to be predictive of eye involvement (Herpes Zoster Ophthalmicus). Herpes zoster affecting the facial nerve resulting in ear pain, taste loss, facial weakness or paralysis, and other neurological symptoms.
- The condition is considered an ophthalmologic emergency due to the risk of vision loss if not quickly identified and treated early in the disease course. Pharmacists are required to immediately refer these patients to an emergency department for urgent medical assessment.

Aute retinal necrosis

- VZV is the leading cause of acute retinal necrosis, which can occur in immunocompetent and immunocompromised people.
- Clinical features include acute iridocyclitis, vitritis, necrotizing retinitis, occlusive retinal vasculitis with rapid loss of vision, and eventual retinal detachment. Blurred vision is characteristic, and pain is present in the affected eye due to progressive necrotizing retinitis.
- Initial disease is usually unilateral but can subsequently involve the other eye in 33 to 50% of patients.
- The condition is considered an ophthalmologic emergency due to the risk of vision loss if not quickly identified and treated early in the disease course. Pharmacists are required to immediately refer these patients to an emergency department for urgent medical assessment.

Disseminated zoster (VZV dissemination)

- Whilst most individuals have some lesions external to the primary dermatome, disseminated zoster is defined as 20 or more lesions outside of the dermatome and may be clinically indistinguishable from varicella infection.
- Viral dissemination to the central nervous system and viscera (lungs, gut, liver and brain) may occur.
- Occurs more frequently in immunocompromised patients, although rare overall.

- Suggested by: >2 contiguous dermatomes, bilateral involvement [lesions crossing the midline], involvement of non-contiguous dermatomes, visceral involvement
- Pharmacists are required to immediately refer these patients to an emergency department for urgent medical assessment.

Other complications

- Neurological complications such as meningoencephalitis, peripheral motor neuropathy, myelitis, Guillain-Barre syndrome, stroke syndromes
- Secondary bacterial skin infections (referral to a medical practitioner for swab and culture is required).
- Moderate to severe nociceptive pain associated with shingles or PHN.
- Patients who are immunocompromised due to underlying medical condition (e.g. transplant recipients, patients with malignancies, patients receiving chemotherapy, HIV infection, uncontrolled diabetes, advanced age) or due to medication taken by the patient (such as immunomodulatory therapy, prednisone therapy).
- Pneumonia.
- Scarring.

Pregnancy & breastfeeding

- Pregnant people who are exposed to VZV (chicken pox or herpes zoster) for the first time (no or uncertain history of previous chicken pox infection) may develop chicken pox which can have serious consequences, including maternal mortality and morbidity, foetal varicella syndrome and the associated abnormalities. Urgent referral to an emergency department is required as zoster immunoglobulin (ZIG) should be given to all seronegative women within 96 hours (4 days).

Patient Assessment

A patient history and examination that is tailored to the patient's presentation is required to inform the management approach, including appropriate referral. The prompts provided below are not exhaustive, pharmacists should maintain an open mind and be aware of cognitive bias.

PATIENT HISTORY

Sufficient information must be obtained from the patient to assess the safety and appropriateness of management. The My Health Record should be reviewed where appropriate and available.

The patient history should include:

- Age
- Pregnancy and lactation status (if applicable)
- Nature, sensitivity and frequency of symptoms
- Nature of rash (distribution, appearance, number of lesions)
- Onset and duration of symptoms
- Precipitating and relieving factors
- History of VZV infection
- Underling medical conditions including: immunocompromise, auto-immune diseases, diabetes, rheumatoid arthritis, inflammatory bowel disease, HIV, cancer, conditions treated with immunosuppressant or immunomodulator therapies (including corticosteroids), renal impairment, transplant recipients, chronic lung conditions
- Current medications (including prescribed medications, vitamins, herbs, other supplements and over-the-counter medications)
- Medication and other strategies used to treat current symptoms
- Drug allergies/adverse drug events

- Immunisation status as per the Australian Immunisation Handbook (AIH) (herpes zoster and varicella vaccinations)

EXAMINATION

- Examination of the rash and documentation of its characteristics and location, as well as any signs of complication. Exclusion of other conditions with similar presentation.
- Laboratory confirmation is generally not required for typical presentations and uncomplicated cases of herpes zoster. Confirmatory pathology testing (initiated by a medical practitioner) is required for cases where diagnosis is uncertain, when complicated disease is a possibility, or in cases of herpes zoster in people who have been previously vaccinated against herpes zoster.
- Patients with signs or symptoms of eye involvement require urgent review by a medical practitioner.

Management and Treatment Plan

- Antiviral treatment can reduce acute pain, duration of the rash, viral shedding and ocular complications if commenced within 72 hours of the first appearance of the rash but is not indicated in all patients.
- Antiviral therapy is indicated for the following groups:
    - All patients who present within 72 hours of onset of the rash as outlined in the Practice Standards should be provided with antiviral therapy
    - Immunocompromised patients (including those with HIV infection) regardless of the time elapsed since the onset of rash. These patients require urgent referral to a medical practitioner.
    - Patients with herpes zoster ophthalmicus regardless of time lapsed from rash onset. These patients require urgent referral to a medical practitioner.

Pharmacist management of herpes zoster involves:

Supportive management

- Education and advice regarding care for lesions: use of dressings, cleaning and appropriate clothing.
- Education and advice regarding transmission precautions in accordance with Healthdirect: Shingles

Chief Health Officer Notification

- Under the *Public Health Act 1997*, any person responsible for the care, counselling, support or education of someone with a notifiable condition is required to notify the Chief Health Officer.
- Any varicella infection, including chickenpox, shingles and unspecified, must be reported to the Chief Health Officer as a notifiable condition within five (5) working days.
- Information about the reporting of notifiable conditions is available at www.act.gov.au/health/reporting-notifiable-diseases.

Pharmacotherapy

- Antiviral therapy in accordance with Therapeutic Guidelines: Shingles.
- Analgesia for mild nociceptive shingles pain within normal over-the-counter pharmacist scope of practice. All patients requiring more substantial analgesia, presenting with neuropathic pain, or presenting with moderate to severe nociceptive pain require a referral to a medical practitioner.

Counselling

- Comprehensive advice and counselling (including supporting written information when required) as per the Therapeutic Guidelines, Australian Medicines Handbook, and other relevant references should be provided to the patient regarding:
    - Medicine use (e.g. dosing)
    - How to manage side effects
    - Recommendations for vaccination against herpes zoster
    - When to seek further care and/or treatment, including recognising superinfection and herpes zoster complications
    - When to return to the pharmacist for a review.
- The agreed management plan must be documented in the patient electronic clinical record and shared with members of the patient's multidisciplinary team, in accordance with the Authority.
- Where a patient has a My Health Record, the pharmacist must ensure the details of the supply are uploaded to My Health Record, unless requested otherwise by the patient.
- All patients should be advised to contact a medical practitioner if:
    - They are not responding to treatment
    - Their signs and symptoms worsen
    - They are experiencing complications (as soon as they become evident)
    - They are having unmanageable adverse effects.

Preventing Transmission

- The patient should be advised to inform any high-risk contacts (pregnant people, neonates in the first month of life and immunocompromised individuals) who have had significant exposure to a person with active VZV (household contacts or where there has been direct face-to-face contact for 5 minutes or being within the same roof for at least an hour) to seek medical care as soon as possible.
- People with herpes zoster are infectious from 1-2 days prior to the onset of the rash, until vesicles have dried and scabbed (usually 5 days after the onset of the rash)
    - Rashes should be covered with appropriate dressings until the patient is no longer infectious and contact with pregnant people, neonates, and immunocompromised people must be avoided.

Zoster Vaccination

- Vaccination against herpes zoster is the best way to prevent herpes zoster and reduce the risk of complications but is not indicated during an acute herpes zoster episode or to treat PHN.
    - People who have had a previous episode of herpes zoster can be vaccinated against a recurrence; the interval between the episode and vaccination is dependent on the patient's immune status
    - Refer to the Australian Immunisation Handbook for herpes zoster information and recommendations
    - The optimal age to be vaccinated against herpes zoster and the vaccine type will differ based on immune status, duration of protection of chosen vaccine and the individual's choice.

Follow-Up Care and Review

- Clinical review with the pharmacist should occur in line with recommendations in the Therapeutic Guidelines.
- Patients should be advised and educated on how and when to seek a review with medical practitioner.
- If a patient experiences worsening of symptoms, minimal improvement in symptoms after commencing pharmacist care, or onset of herpes zoster complications, they must be referred for an urgent review by a medical practitioner.
- A clinical review is recommended 48-72 hours after the initial presentation to assess for:
    - Progression of the rash
    - The clinical signs or symptoms of herpes zoster
    - Screening for complications of herpes zoster
    - Adverse effects of therapy.

Clinical Documentation and Communication

- The pharmacist must make an electronic clinical record, and a record in a pharmacy dispensing system regarding the supply of any medications under these services, in accordance with the Authority.
- Where a patient has a My Health Record, the pharmacist must ensure the details of the supply are uploaded to My Health Record, unless requested otherwise by the patient.

Resources

Patient information/resources:

- It is the pharmacist's responsibility to ensure the suitability and accuracy of any resources provided to patients.
- NSW Health: Fact sheets: Shingles fact sheet
- Healthdirect: Shingles
- UpToDate Patient education: Shingles (The Basics)
- UpToDate Patient education: Patient education: Shingles (Beyond the Basics)

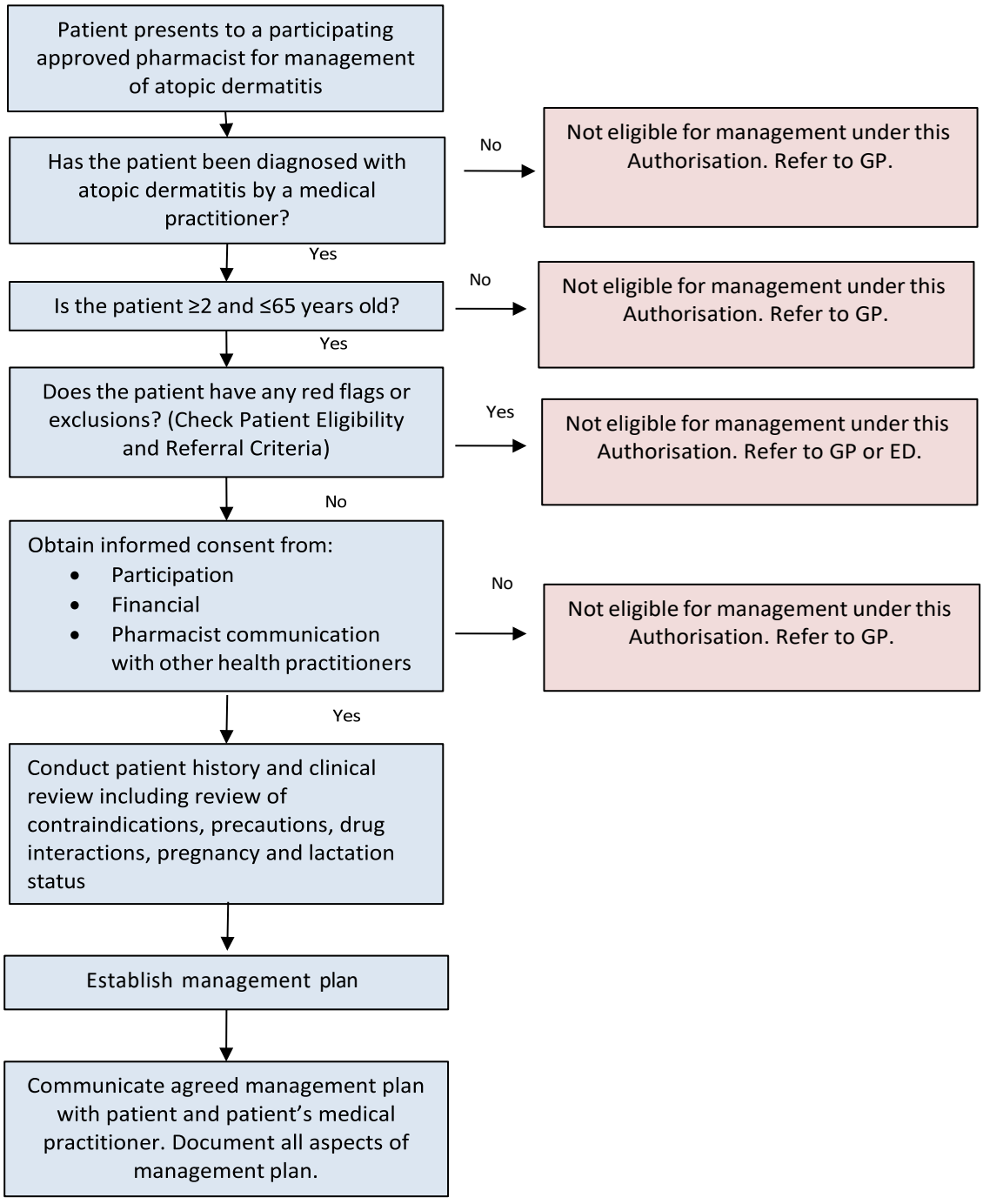
Pharmacist resources:

- Therapeutic Guidelines: Antibiotic
    - Shingles
    - Herpes Zoster Opthalmicus
- Australian Medicines Handbook
    - Antivirals
- Australian Immunisation Handbook: Zoster (herpes zoster)
- National Centre for Immunisation Research and Surveillance: Factsheet: Zoster vaccines for Australian adults
- DermNet NZ:
    - Herpes zoster
    - Herpes zoster images
    - Blistering skin conditions
- MSD Manual (Professional version): Herpes Zoster
- Public Health (Notifiable Conditions) Determination 2022 (No 2)

Appendix Part 3.C – Mild to Moderate Atopic Dermatitis Clinical Protocol

Patient Assessment Flowchart

This clinical protocol has been adapted from the NSW Pharmacist Practice Standards for the treatment of Mild to Moderate Atopic Dermatitis created by NSW Health and adapted for the ACT and used with permission.



Supplementary Information and Notes

This supplementary information provides guidance for pharmacists managing patients with mild to moderate atopic dermatitis under this Authority. It is to be used together with the training modules and other resources provided by education providers.

Key points

- To receive management for mild to moderate atopic dermatitis under this service, the patient must fulfil the eligibility requirements set out under Part D of Appendix C of this document. Patients who have requested the service but are not eligible for management should be referred to their regular medical practitioner or health service.
- Pharmacists can supply up to 14 days of therapy before referring a patient to a medical practitioner, or a higher quantity as specified in this Authorisation.
- Pharmacists must only supply formulations listed in this Authorisation.
- Patients must be physically present in the pharmacy to be eligible for management.
- Patients are required to have a consultation with an approved pharmacist before a medication can be supplied under the Authority.
- Pharmacists must make a full clinical record of the consultation and the details of all consultations and outcomes must be recorded using secure digital software. Records must be stored securely for minimum seven (7) years or, in the case of health information collected while the patient was under the age of 18 years, until the patient has attained the age of 25 years.
- Pharmacists must exercise professional discretion and judgement when applying the information within these Practice Standards. The Practice Standards do not override the responsibility of the pharmacist to make decisions appropriate to the circumstance of the individual, in consultation with their patient.

Patient Consent

The pharmacist must seek the patient's consent to share a record of the consultation and any subsequent consultations (including adverse events) with the patient's usual treating medical practitioner or medical practice, where the patient has one, following consent by the patient. If the patient **does** consent to the disclosure, the record must be shared within seven (7) days following the consultation.

Communication with the patient's usual treating medical practitioner or medical practice should ensure patient confidentiality is maintained. Use of a secure digital messaging platform is considered best practice.

Patient Eligibility and Referral Criteria

- Patients must be aged between 2 years and 65 years (inclusive) to be eligible for the service.
- Patients who meet any of the urgent referral criteria below must be referred to their regular medical practitioner, maternity provider, health service, or Emergency Department (ED) as indicated in the table.
- Pharmacists must not provide management to individuals specified in the table below, where there is a 'No' in the 'Treat' column for the patient group and must take appropriate action in accordance with established referral pathways.

- Pharmacists must apply clinical judgement and refer any patient considered appropriate for medical care.
- Pharmacists must consult the Therapeutic Guidelines and other relevant references to confirm management is appropriate, including for:
    - Contraindications and precautions
    - Drug interactions
    - Pregnancy and lactation

	Referral criteria	Treat	Referral
Red flag' warning signs	Severe or widespread or painful rash	No	Urgent: ED
	Raised purple rash that doesn't blanch	No	Urgent: ED
	Generalised erythema that covers 90% or more of the skin (this is a medical emergency and requires immediate ED referral)	No	Urgent: ED
	Signs of sepsis, systemic illness or other complications such as: fever, confusion, lethargy, tachycardia, hypotension, hypertension, clammy skin, rash, nausea, vomiting, diarrhoea, facial or peripheral oedema, headache, joint pain and/or swollen joints	No	Urgent: ED
	Blistering of the skin and mucous membranes (including mouth and eyes)	No	Urgent: ED
	Non-healing broken skin, sores, ulcers or crusts that are chronic (more than 4 weeks)	No	Urgent: ED
	Immunocompromised patients • due to underlying medical condition (e.g. transplant recipients, patients with malignancies, patients receiving chemotherapy, HIV infection, uncontrolled diabetes, advanced age) • due to medication taken by the patient (such as immunomodulatory therapy, prednisone therapy)	No	Urgent: ED or GP
	Significant body surface area involvement (>30% body surface area)	No	GP
	The condition is having a marked negative emotional and social effect	No	GP
	Complex presentation, such as those requiring antibiotic therapy for secondary infection. Pharmacists must not supply antibiotic therapy.	No	GP
Details of presenting complaint	The patient is below 2 years or over 65 years of age	No	GP
	The diagnosis is unclear	No	GP
	The patient has not been diagnosed with atopic dermatitis by a medical practitioner	No	GP
	Atopic dermatitis affecting the genitals	No	GP
	Pregnant or planning a pregnancy	No	GP
	Atypical presentations of atopic dermatitis (i.e. not classic atopic dermatitis)	No	GP
	A paediatric patient that presents with a history of immediate or delayed-type hypersensitivity to food, poor feeding or sleep, concerns about failure to thrive	No	GP
	Patient presents with or develops complication (e.g. eczema herpeticum)	No	GP
	There is no response to optimal treatment (within 7 days) or the condition worsens or reoccurs	No	GP
	Patient requires large quantities of topical products (such as topical corticosteroids) that require an authority from the pharmaceutical benefits scheme	No	GP

Background

- Atopic dermatitis is a chronic inflammatory skin disease.
- It is characterised by pruritic, scratching and dry, scaly, erythematous, crusted patches. It can affect any area of skin, but typically occurs on the face, cubital and popliteal fossae

(behind the elbows and knees), wrists and ankles. Atopic dermatitis is the result of a complex interplay between genetic and environmental factors. It follows a relapsing course with flares at varying frequency and periods of remission.

- Both pruritus and rash must be present for a diagnosis of atopic dermatitis. Only patients who have previous been diagnosed with atopic dermatitis by a medical practitioner can be managed by pharmacists under these Practice Standards.
- Atopic dermatitis imposes a significant financial, psychological and social burden on the lives of patients and their families, and is associated with poor sleep, depression, anxiety, poor self-esteem and reduced quality of life.
- Secondary infection is a common complication of atopic dermatitis. If a secondary infection co-occurs in the presentation, the patient must be referred to a medical practitioner for investigation and management. Treatment of infection in atopic dermatitis is beyond the scope of these Practice Standards and requires a referral to a medical practitioner.
- Patients with atopic dermatitis are more likely to have an immediate or family history of atopic conditions (e.g. allergic rhinitis and asthma).
- Atopic dermatitis is often misdiagnosed as a contact irritant or allergic dermatitis. Pharmacists must be aware of potential differential diagnoses and refer these presentations for management by a medical practitioner. Only management of atopic dermatitis is permitted under these Practice Standards.
- Itch is the most significant complaint in patients presenting with atopic dermatitis and is a complicating factor of the disease. Pharmacists should provide education and advice on the itch-scratch cycle and how to manage itch appropriately.
- Aggravating and triggering factors cause flare-ups of atopic dermatitis and can impair response to treatment. Regular use of moisturisers (emollients) and avoiding aggravating and triggering factors are a central component of managing atopic dermatitis.
- Treatment of acute atopic dermatitis usually involves topical corticosteroids in combination with emollients, identification and avoidance of triggers, and the early treatment of infection. Treatment of infection in atopic dermatitis is beyond the scope of these Practice Standards and requires a referral to a medical practitioner.
- Clinical features:
    - Atopic dermatitis is characterised by dry, scaly erythematous patches with the primary hallmark being itch.
    - Atopic dermatitis can affect any area of the skin, the most common locations are the face, inside of the elbow/arm (cubital fossa), back of the knee (popliteal fossa), wrist and ankles
    - The skin signs of atopic dermatitis may vary depending on age and ethnicity
    - People with atopic dermatitis are at a higher risk of allergic contact reactions (e.g. nickel is a common contact allergen) and are prone to other viral skin infections (e.g. common warts and molluscum contagiosum)
- Severity:
    - SCORing Atopic Dermatitis (SCORAD) index and the Eczema Area and Severity Index (EASI) can be used to assess the severity of atopic dermatitis to determine whether the patient requires a referral and to inform the treatment plan and monitor treatment effectiveness. Use of these scoring systems are beyond the scope of these Practice Standards.
    - Conventional scoring systems may underestimate severity and erythema in people with darker skin tones including Aboriginal and Torres Strait Islander and Pacific Islander populations, and people of African descent. Consider the skin tone when assessing erythema.

- Patients presenting with generalised erythema that covers 90% of the skin require urgent referral to a medical practitioner.
- All severe cases of atopic dermatitis must be urgently referred to a medical practitioner for management without any treatment by the pharmacists.

Complications of Atopic Dermatitis

Caution must be exercised by pharmacists managing patients with suspected complex presentations and complications of atopic dermatitis. Pharmacists are required to immediately refer these patients for urgent medical assessment at presentation or at any stage if a complication develops.

- Secondary infections (bacterial, viral and fungal) are the most common complications of atopic dermatitis due to an inherently abnormal skin barrier cutaneous and systemic immune system abnormalities and scratching the itch.
    - Early treatment of the concurrent infection is important for successful management of active atopic dermatitis
    - Suspected co-occurrence of a secondary infection must be referred to a medical practitioner for investigation and management
    - **Eczema herpeticum** is an infection of atopic dermatitis with herpes simplex virus (HSV)
        - Vesicles develop usually in areas of active or recent atopic dermatitis, followed by the onset of high fever and adenopathy
        - Painful corneal lesions will develop if the eye is involved and if the HSV infection becomes systemic. This may be fatal. This is a medical emergency. Pharmacists are required to immediately refer these patients to an emergency department for urgent medical assessment.
    - Clinical signs of impetiginisation are itch, red or darker areas of atopic dermatitis, progressing to weeping and crusting, periauricular fissuration, or small superficial pustules

Patient Assessment

A patient history and examination that is tailored to the patient's presentation is required to inform the management approach, including appropriate referral. The prompts provided below are not exhaustive, pharmacists should maintain an open mind and be aware of cognitive bias.

PATIENT HISTORY

Sufficient information must be obtained from the patient to assess the safety and appropriateness of management. The My Health Record should be reviewed where appropriate and available.

The patient history should include:

- Age
- Weight (if a child)
- Pregnancy and lactation status (if applicable)
- Onset, duration, nature, location, severity and extent of the rash including recent or previous relapse or flare ups, and other symptoms
- Previous diagnosis of atopic dermatitis and any current or past management plan
- Underlying associated medical conditions including asthma, allergic rhinitis, allergic conjunctivitis, allergic contact dermatitis, food allergy and depression

- Details of and response to previous treatments
- Impacts on quality of life and psychosocial wellbeing including sleep and learning
- Dietary history and changes in diet
- Exposure to potential triggers or irritants
- Other factors including family history, environmental factors (e.g. exposure to smoking and airborne pollution) and infectious factors
- Current, recently commenced or recently ceased medications (including prescribed medications, vitamins, herbs, other supplements and over-the-counter medicines)
- Allergies/adverse drug events.

EXAMINATION

- Physical examination of the patient's skin is required to identify, assess and classify the severity of an acute exacerbation of atopic dermatitis. Itching and rash must be present.

Management and Treatment Plan

Pharmacists need to refer to the Therapeutic Guidelines and the Australian Medicines Handbook for details on management.

Pharmacist management of mild to moderate atopic dermatitis involves:

- Development of an Eczema Action Plan:
    - Based on the Australasian Society of Clinical Immunology and Allergy Action Plan for Eczema template
- Non-pharmacological/general measures:
    - Advice regarding skin care and minimising aggravating factors
    - Advice on how to manage the itch-scratch cycle
- Pharmacotherapy as per the Therapeutic Guidelines
    - Patients should be advised that each new treatment may take time to work and should be trialled for 7 days. If there is no improvement, then patient must be referred to a medical practitioner.
    - Pharmacists can only manage mild to moderate presentations of atopic dermatitis that has previously been diagnosed by a medical practitioner as part of these Practice Standards.
    - Topical corticosteroids
        - Selecting the correct potency and formulation of topical corticosteroids is important to avoid both undertreatment and fears around topical corticosteroids use. Pharmacists should consult the Therapeutic Guidelines: Consideration in the use of topical corticosteroids, the Australian Medicines Handbook: Corticosteroid (skin) and the Australian College of Dermatologists consensus statements on Management of atopic dermatitis in adults and Topical corticosteroids in paediatric eczema, and other relevant sources.
        - For management of the face, pharmacists must use hydrocortisone 1% ointment only. All stronger potency corticosteroid therapies cannot be supplied by the pharmacist under the Practice Standards and can only be prescribed by a medical practitioner.
        - For management of flexural sites, pharmacists must use hydrocortisone 1% ointment or desonide 0.05% lotion only. All stronger potency corticosteroid therapies cannot be supplied by the

pharmacist under the Practice Standards and can only be prescribed by a medical practitioner.
        - Management of the groin is beyond the scope of the Practice Standards.
        - For management of the scalp in children, pharmacists can use desonide 0.05% lotion or methylprednisolone aceponate 0.1% lotion only.
    - Tar preparations can cause sensitivity reactions and are beyond the scope of these Practice Standards and can only be initiated by a medical practitioner.
    - Therapeutic regimens for atopic dermatitis can be expensive and complicated, making long-term compliance difficult and leading to poor outcomes for patients. Choice of treatment should consider the impact of factors such as age, socioeconomic status, cost and literacy on the patient's ability to adhere to prescribed therapies.

Counselling

- Comprehensive advice and counselling (including supportive written information when required) should be provided to the patient regarding:
    - Product and medication use: dosing and application instructions for topical corticosteroids, emollients, and other topical products, wet dressing use)
    - How to manage adverse reactions
    - When to seek further care and/or treatment from a medical practitioner
    - How to recognise infection
    - When to return for a clinical review
    - How to manage the itch-scratch cycle
- Treatment may be unsuccessful when there is poor adherence with therapy, skin infection, allergy or severe dermatitis.
- Patient should be advised to immediately see a medical practitioner if symptoms worsen after commencing treatment.
- Common adverse effects of topical corticosteroids such as transient burning, stinging or pain on application can generally be reversed by stopping the medication. Referral to a medical practitioner is required if the adverse effect does not resolve quickly.
- When recommending topical corticosteroids for atopic dermatitis, pharmacists should reassure patients/caregivers who have concerns about the safety of topical corticosteroids that they are safe when used appropriately.
- The agreed management plan must be documented in the patient electronic clinical record and shared with members of the patient's multidisciplinary team, in accordance with the Authority.
- Where a patient has a My Health Record, the pharmacist must ensure the details of the supply are uploaded to My Health Record, unless requested otherwise by the patient.
- All patients should be advised to contact a medical practitioner if:
    - They are not responding to treatment (within 7 days)
    - Their signs and symptoms worsen
    - They are experiencing complications (as soon as they become evident)
    - They are having unmanageable adverse effects.

FOLLOW-UP CARE AND REVIEW

- Clinical review with the pharmacist should occur in line with recommendations in the Therapeutic Guidelines.
- Patients should be advised and educated on how and when to seek a review with medical practitioner
- If a patient experiences worsening of symptoms, minimal improvement in symptoms after commencing pharmacist care, a secondary infection, they must be referred for an urgent review by a medical practitioner.
- Clinical review is recommended 7 to 14 days after the initiation of treatment for acute atopic dermatitis to assess:
    - Response to treatment
    - Adverse effects
    - If changes are required to the treatment plan, decisions to continue, modify or stop treatment should be reflected in the patient's eczema action plan.
- If a good response has been achieved, the medication can be reduced or stopped, and the patient can continue using regular moisturiser only.
- If there has been an inadequate response to therapy due to compliance issues such as inappropriate use, or a patient not applying enough medication, the pharmacist may provide further advice.
- Pharmacists should generally only supply a sufficient quantity of medicine (including repeats) for the period until the patients review. Pharmacists can only supply a maximum of 14 days of therapy under these Practice Standards.
- Pharmacotherapy for management of atopic dermatitis may be required longer-term; pharmacists should refer patients to a medical practitioner for a review and ongoing management after the acute flare has been managed. An annual review by a medical practitioner is recommended to assess for adverse effects from topical corticosteroid therapy.

Clinical Documentation and Communication

- The pharmacist must make an electronic clinical record, and a record in a pharmacy dispensing system regarding the supply of any medications under these services, in accordance with the Authority.
- Where a patient has a My Health Record, the pharmacist must ensure the details of the supply are uploaded to My Health Record, unless requested otherwise by the patient.

Resources

Patient information/resources:

- It is the pharmacist's responsibility to ensure the suitability and accuracy of any resources provided to patients.
- Eczema Association Australia: How to manage Eczema
- American Academy of Dermatology Association: Eczema Resource Centre
- Therapeutic Guidelines: Modified dressings for inflammatory dermatoses
- The Royal Children's Hospital Melbourne: Kids Health Info: Fact sheets: Eczema
- Raising Children: Eczema
- Healthdirect: Eczema
- Ask the Allergist: Breaking the Itch-Scratch Cycle
- Itching and scratching: How to control eczema-related itching

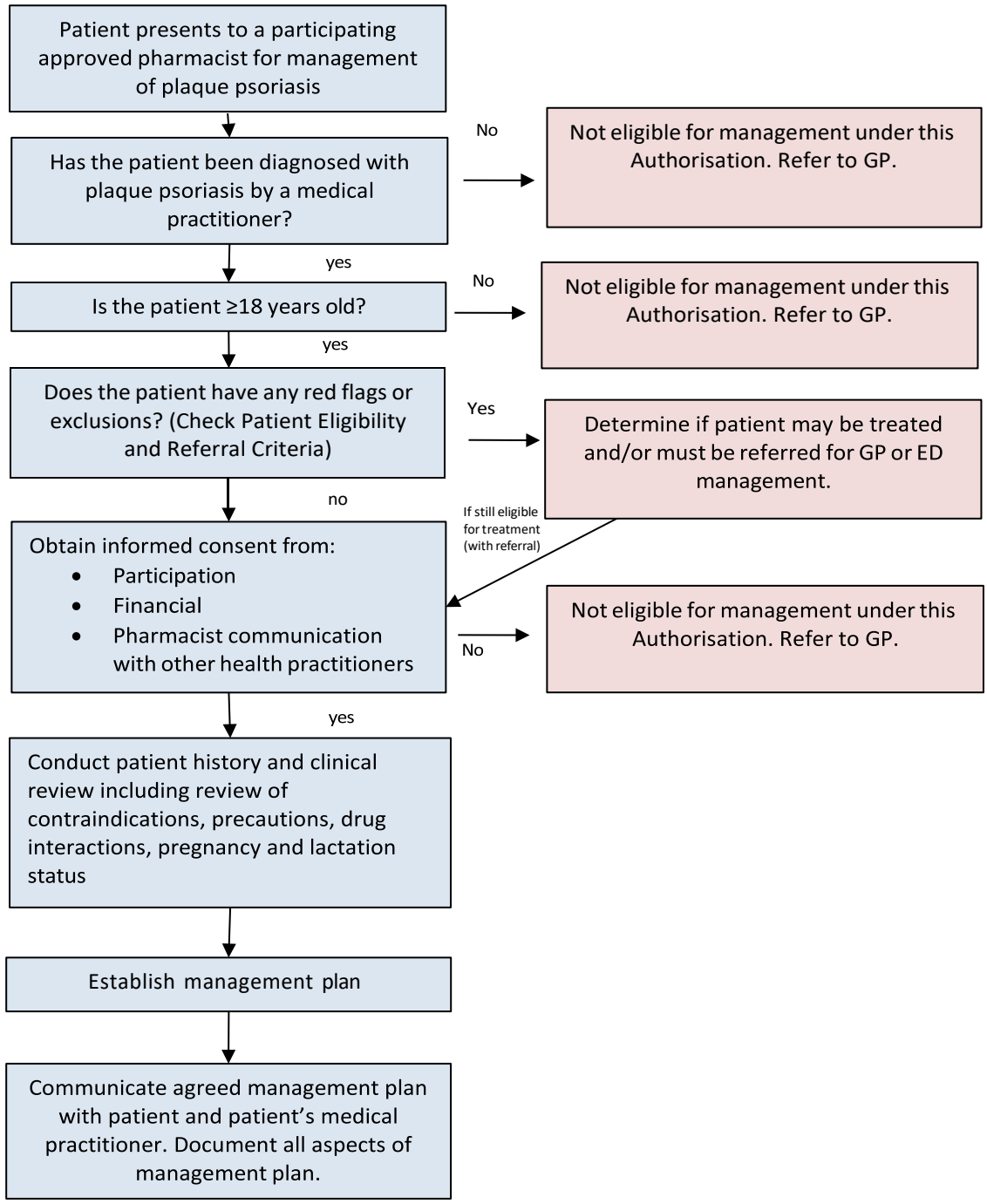
Pharmacist resources:

- Therapeutic Guidelines:
  - Dermatology: Atopic dermatitis
  - Dermatology: Topical corticosteroids for atopic dermatitis
- Australian Medicines Handbook:
  - Drugs for Eczema
  - General principles: topical treatment of skin conditions
  - Topical steroids: how much do I use
- DermNet NZ:
  - Atopic dermatitis
  - Atopic dermatitis images
  - Guidelines for the diagnosis and assessment of eczema
  - Fingertip unit
- MSD Manual (Professional version): Atopic dermatitis (Eczema)
- Australian Journal of General Practice: Selection of an effective topical steroid
- Australasian Society of Clinical Immunology and Allergy: Action Plan for eczema
- Australasian College of Dermatologists
  - Consensus statement: Management of atopic dermatitis in adults
  - Consensus statement: Topical corticosteroids in paediatric eczema
  - A-Z of skin: Atopic dermatitis
- Skin Deep: An open access bank of high-quality photographs of medical conditions in a wide range of skin tones for use by both healthcare professionals and the public
- Royal Children's Hospital Melbourne – Clinical Practice Guidelines for Eczema
- National Eczema Association: Managing itch

Appendix Part 4.D – Mild Plaque Psoriasis Clinical Protocol

Patient Assessment Flowchart

This clinical protocol has been adapted from the NSW Pharmacist Practice Standards for the treatment of Mild Plaque Psoriasis created by NSW Health and adapted for the ACT and used with permission.



Supplementary Information and Notes

This supplementary information provides guidance for pharmacists managing patients with mild plaque psoriasis under this Authority. It is to be used together with the training modules and other resources provided by education providers.

Key points

- To receive management for mild plaque psoriasis under this service, the patient must fulfil the eligibility requirements set out under Part D of Appendix D of this document. Patients who have requested the service but are not eligible for management should be referred to their regular medical practitioner or health service.
- Pharmacists can supply up to 4 weeks of therapy before referring a patient to a medical practitioner, or a higher quantity as specified in this Authorisation.
- Pharmacists must only supply formulations listed in this Authorisation.
- Patients must be physically present in the pharmacy to be eligible for management.
- Patients are required to have a consultation with an approved pharmacist before a medication can be supplied under the Authority.
- Pharmacists must make a full clinical record of the consultation and the details of all consultations and outcomes must be recorded using secure digital software. Records must be stored securely for minimum seven (7) years.
- Pharmacists must exercise professional discretion and judgement when applying the information within these Practice Standards. The Practice Standards do not override the responsibility of the pharmacist to make decisions appropriate to the circumstance of the individual, in consultation with their patient.

Patient Consent

The pharmacist must seek the patient's consent to share a record of the consultation and any subsequent consultations (including adverse events) with the patient's usual treating medical practitioner or medical practice, where the patient has one, following consent by the patient. If the patient **does** consent to the disclosure, the record must be shared within seven (7) days following the consultation.

Communication with the patient's usual treating medical practitioner or medical practice should ensure patient confidentiality is maintained. Use of a secure digital messaging platform is considered best practice.

Patient Eligibility and Referral Criteria

- Patients must be aged 18 years or older to be eligible for the service.
- Patients who meet any of the urgent referral criteria below must be referred to their regular medical practitioner, maternity provider, health service, or Emergency Department (ED) as indicated in the table. Note that these are not exhaustive lists.
- Pharmacists must not provide management to individuals specified in the table below, where there is a 'No' in the 'Treat' column for the patient group and must take appropriate action in accordance with established referral pathways.
- Pharmacists must apply clinical judgement and refer any patient considered appropriate for medical care.

- Pharmacists must consult the Therapeutic Guidelines and other relevant references to confirm management is appropriate, including for:
    - Contraindications and precautions
    - Drug interactions
    - Pregnancy and lactation

	Referral criteria	Treat	Referral
'Red flag' warning signs	Guttate psoriasis	No	Urgent: GP
	Pustular psoriasis	No	Urgent: GP
	Erythrodermic psoriasis	No	Urgent: GP
	Psoriasis affecting the face, scalp, genitals, palms, soles, nails	No	Urgent: GP
	Severe plaque psoriasis (>25% body surface area)	No	Urgent: GP
	Signs of sepsis, systemic illness or other complications such as: fever, confusion, lethargy, tachycardia, hypotension, hypertension, clammy skin, rash, nausea, vomiting, diarrhoea, facial or peripheral oedema, headache, joint pain and/or swollen joints	No	Urgent: ED
	Complex presentation, such as those requiring antibiotic therapy for secondary infection. Pharmacists must not supply antibiotic therapy.	No	Urgent: GP
	Immunocompromised patients • due to underlying medical condition (e.g. transplant recipients, patients with malignancies, patients receiving chemotherapy, HIV infection, uncontrolled diabetes, advanced age) • due to medication taken by the patient (such as immunomodulatory therapy, prednisone therapy)	No	Urgent: ED or GP
	Non-healing broken skin, sores, ulcers or crusts that are chronic (more than 4 weeks)	No	Urgent: ED
	The condition is having a marked emotional and/or social impact on the patient	No	Urgent: GP
	Patients at risk of comorbid disease (e.g. hypertension, obesity, heart disease, diabetes, depression, arthritis)	Yes	GP
	Referral criteria	**Treat**	**Referral**
Details of presenting complaint	The patient is below 18 years of age	No	GP
	The diagnosis is unclear	No	GP
	The patient has not been diagnosed with psoriasis by a medical practitioner	No	GP
	Moderate plaque psoriasis (>10% body surface area)	No	GP
	Psoriasis affecting the face, scalp, genitals, groin, palms, soles, nails	No	GP
	The patient has not seen a medical practitioner for a review of their condition in the previous 12 months	No	GP
	Pregnant or planning pregnancy	No	GP
	The patient is taking a medication that can exacerbate psoriasis	No	GP
	There is no response to optimal treatment (within 2-4 weeks) or the condition worsens or reoccurs	No	GP

Background

- Psoriasis is a common, chronic, noncontagious, multisystem autoinflammatory disease. It is complex in its aetiology and pathogenesis and is influenced by genetic and immune-related components. It causes a rash with itchy, scaly patches most commonly on the knees, elbows, trunk and scalp.
- Psoriasis is associated with an increased risk of comorbidities including cardiovascular disease, hypertension, obesity, metabolic syndrome, hypercholesterolaemia, diabetes, hepatosteatosis, inflammatory bowel disease, lymphoma and depression. Patients who have not had these issues addressed with their medical practitioner should be referred for investigations and management.
- Up to 35% of patients with chronic plaque psoriasis have an associated spondyloarthropathy; this condition is called psoriatic arthritis and requires referral to a medical practitioner for management.
- The characteristic form of psoriasis (plaque psoriasis, also known as psoriasis vulgaris) presents with erythematous, scaly papules and plaques. Morphological variants include guttate, palmoplantar, erythrodermic, inverse (flexural), and pustular psoriasis. Only patients presenting with an acute exacerbation of mild plaque psoriasis that has previously been diagnosed by a medical practitioner may receive management under these Practice Standards. All other psoriasis presentations necessitate a referral to a medical practitioner.
- In darker skin tones, plaques are generally darker or violet in colour, thicker and with more obvious scale and itch.
- Nail changes, including pitting, lifting of the nail (onycholysis) and subungual hyperkeratosis may also be observed, although it may be difficult to distinguish nail changes due to psoriasis from fungal nail infections. Any presentations involving these anatomical regions are outside the scope of these Practice Standards and must be referred to a medical practitioner for management.
- Psoriasis can have marked functional, psychological and social impacts, which may or may not correlate with severity. Psoriasis is difficult to treat, associated with poor cosmetic outcomes and considered severe when it occurs on the face, nails, scalp, genitals, groin, palms and soles. These anatomical areas are outside the scope of practice for pharmacists in these Practice Standards and must be referred to a medical practitioner for management.
- Secondary infection with dermatophyte is common in psoriasis, often when a patient already has an established diagnosis. Referral to a medical practitioner is required if there is an unusual flare of the condition particularly in the groin, lower legs or feet.
- Psoriasis may be triggered for the first time by infections such as streptococcal tonsillitis, HIV and other viral infections, as well as by severe emotional stress.
- Smoking and excessive alcohol intake may worsen the condition. Pharmacists should offer counselling to assist patients in quitting smoking and modifying and identified lifestyle risks.
- Some medications may trigger psoriasis or cause psoriasis to become more severe. These medications include lithium, beta-blockers, anti-malarial medication, and rapid withdrawal of systemic corticosteroids.

Factors that can aggravate psoriasis	
• Streptococcal tonsillitis (strep throat) and other infections e.g. viral • Skin trauma and injuries such as cuts, abrasions, sunburn • Sun exposure (although gentle exposure is often beneficial) • Dry skin • Obesity • Metabolic factors • Smoking • Sleep deprivation and emotional stress	• Excessive alcohol consumption • Hormonal factors • Pregnancy and postpartum stages • Medicines such as lithium, beta-blockers, antimalarials, nonsteroidal anti-inflammatories, antibiotics, ace inhibitors, TNFα inhibitors • Stopping oral steroids or potent topical corticosteroids • Other environmental factors (e.g. stressful life event)

- Disease severity
    - Severity is classified according to percentage of body surface involved combined with plaque thickness and scaling (Psoriasis Area and Severity Index (PASI) score, with moderate-to-severe disease being defined as more than 10% body surface area affected.
    - The Dermatology Life Quality Index (DLQI) is used to measure the health-related quality of life in adult patients with psoriasis. Psoriasis is considered severe with a DLQI score of over 10, regardless of the PASI score. These patients need to be referred to a medical practitioner. Use of these scoring systems are beyond the scope of these Practice Standards.
    - Psoriasis may also be considered severe if there is a significant impact on the patient's quality of life due to involvement of visible areas: major parts of the scalp, genitals, palms/soles, onycholysis of at least 2 fingernails or pruritus leading to excoriation. These patients need to be referred to a medical practitioner.
    - Pharmacists are only able to provide care to patients with presentations of mild disease that has previously been diagnosed by a medical practitioner under these Practice Standards.

Patient Assessment

A patient history and examination that is tailored to the patient's presentation is required to inform the management approach, including appropriate referral. The prompts provided below are not exhaustive, pharmacists should maintain an open mind and be aware of cognitive bias.

PATIENT HISTORY

Sufficient information must be obtained from the patient to assess the safety and appropriateness of management. The My Health Record should be reviewed where appropriate and available.

The patient history should include:

- Age
- Pregnancy and lactation status (if applicable)
- Onset, duration, nature, location, severity and extent of the rash including recent or previous relapse or flare ups, and other symptoms
- Previous diagnosis of atopic dermatitis and any current or past management plan

- Underlying associated medical conditions including asthma, allergic rhinitis, allergic conjunctivitis, allergic contact dermatitis, food allergy and depression
- Details of and response to previous treatments
- Impacts on quality of life and psychosocial wellbeing
- Exposure to factors that can aggravate psoriasis (see table above)
- Current, recently commenced or recently ceased medications (including prescribed medications, vitamins, herbs, other supplements and over-the-counter medicines)
- Family history of psoriasis
- Allergies/adverse drug events.

EXAMINATION

- Physical examination of the patient's skin is required to identify, assess and classify the severity of an acute exacerbation of mild plaque psoriasis

Management and Treatment Plan

There is no cure for psoriasis; the aim of treatment is to clear lesions and manage symptoms with the least burdensome therapy. Most cases of mild plaque psoriasis can be treated with topical therapies.

Pharmacists need to refer to the Therapeutic Guidelines and the Australian Medicines Handbook for details on management.

Pharmacist management of acute exacerbations of mild plaque psoriasis involves:

General measures

- Education and advice regarding lifestyle modification:
    - Smoking cessation
    - Avoiding excess alcohol intake
    - Maintaining optimal weight
- Education and advice regarding daily use of emollients and moisturisers to the skin to maintain skin hydration and barrier function

Pharmacotherapy

- Anatomical areas of the face, nails, scalp, genitals, groin, palms and soles are areas are outside the scope of practice for pharmacists in these Practice Standards and must be referred to a medical practitioner for management.
- Topical treatments as per Therapeutic Guidelines: Psoriasis
    - For management of axillae, pharmacists must use hydrocortisone 1% or hydrozole only. All stronger potency corticosteroid therapies cannot be supplied by the pharmacist under the Practice Standards and can only be prescribed by a medical practitioner.
- Patients should be advised that each new treatment may take time to work and should be trialled for 2 to 4 weeks.

- If symptoms worsen or do not improve after commencing treatment, patients should be advised to stop therapy and immediately seek review by a medical practitioner.
- Pharmacists should review reducing and withdrawing topical corticosteroid therapy, when possible, especially for more potent topical corticosteroids, because of the long-term effects.

Counselling

- Comprehensive advice and counselling (including supportive written information when required) should be provided to the patient regarding:
    - The typical cycle of psoriasis and how to optimise lifestyle factors
    - Expectations of treatment
    - Product and medication use: dosing and application instructions for topical corticosteroids, emollients, and other topical products
    - How to manage adverse reactions
    - When to seek further care and/or treatment from a medical practitioner
    - How to recognise infection
    - When to return for a clinical review.
- Common adverse effects of topical corticosteroids such as transient burning, stinging or pain on application can generally be reversed by stopping the medication. Referral to a medical practitioner is required if the adverse effect does not resolve quickly.
- The agreed management plan must be documented in the patient electronic clinical record and shared with members of the patient's multidisciplinary team, in accordance with the Authority.
- All patients should be advised to contact a medical practitioner if:
    - They are not responding to treatment (within 2-4 weeks)
    - Their signs and symptoms worsen
    - They are experiencing complications (as soon as they become evident)
    - They are having unmanageable adverse effects.

FOLLOW-UP CARE AND REVIEW

- Clinical review with the pharmacist should occur in line with recommendations in the Home | Therapeutic Guidelines.
- Patients should be advised and educated on how and when to seek a review with medical practitioner.
- If a patient experiences worsening of symptoms, minimal improvement in symptoms after commencing pharmacist care, onset of psoriasis. comorbidities, or a secondary infection, they must be referred for an urgent review by a medical practitioner.
- Clinical review is recommended 2-4 weeks after the initiation of treatment for an acute exacerbation to assess:
    - Response to treatment (and compliance)
    - If changes are required to the treatment plan
    - Adverse effects of therapy.

- If good response has been achieved, the medication can be reduced or stopped, and the patient can continue using regular moisturiser only.
- If there has been inadequate response to therapy as a result of compliance issues such as inappropriate use, or a patient not applying enough medication, the pharmacist may provide further advice.
- Pharmacists should generally only supply a sufficient quantity of medicine (including repeats) for the period until the patient's review. Pharmacists can only supply a maximum of 4 weeks of therapy under these Practice Standards, or a higher quantity specified in the Authority.
- Pharmacotherapy for management of psoriasis may be required longer-term; pharmacists should refer patients to a medical practitioner for a review and ongoing management after the acute flare has been managed. An annual review by a medical practitioner is recommended to assess for adverse effects from topical corticosteroid therapy.

Clinical Documentation and Communication

- The pharmacist must make an electronic clinical record, and a record in a pharmacy dispensing system regarding the supply of any medications under these services, in accordance with the Authority.
- Where a patient has a My Health Record, the pharmacist must ensure the details of the supply are uploaded to My Health Record, unless requested otherwise by the patient.

Resources

Patient information/resources:

- It is the pharmacist's responsibility to ensure the suitability and accuracy of any resources provided to patients.
- HealthDirect:
  - Psoriasis
  - Medicines for Psoriasis
- NPS MedicineWise factsheets:
  - Topical treatments for your plaque psoriasis
  - Plaque psoriasis: my options when topical treatments aren't enough
- Skin Health Institute: Patient information sheet
- UpToDate:
  - Patient education: Psoriasis (The Basics)
  - Patient education: Psoriasis (Beyond the Basics)
  - Patient education: Topical corticosteroid medicines (The Basics)
  - Patient education: Itchy skin (The Basics)

Pharmacist resources:

- Therapeutic Guidelines: Dermatology:
  - Psoriasis
  - Considerations in the use of topical corticosteroids
- Australian Medicines Handbook:
  - Psoriasis

    - General principles: topical treatment of skin conditions
    - Corticosteroids (skin)
- DermNet NZ:
    - Psoriasis
    - Fingertip unit
- MSD Manual (Professional version) – Psoriasis
- Journal of Clinical Medicines - Topographic Differential Diagnosis of Chronic Plaque Psoriasis: Challenges and Tricks
- Skin Deep: An open access bank of high-quality photographs of medical conditions in a wide range of skin tones for use by both healthcare professionals and the public
- Mayo Clinic: Psoriasis
- NPS MedicineWise: Psoriasis
- The Australian College of Dermatologists:
    - Consensus statement: Treatment goals for psoriasis
    - A-Z of skin: Psoriasis.

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