February 2024

Protocol for Management of Acute Exacerbation of Mild Plaque Psoriasis

Victorian Community Pharmacist Statewide Pilot

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1. About

This Protocol has been developed to provide pharmacists authorised under the Drugs, Poisons and Controlled Substances Regulations 2017 (the Regulations) a clear framework to supply the Schedule 4 poisons documented in this Protocol for the purpose of managing acute exacerbations of mild plaque psoriasis under a structured prescribing arrangement. It is a requirement of the Secretary Approval: Community Pharmacist Statewide Pilot that pharmacists comply with this Protocol when supplying Schedule 4 poisons for patients seeking treatment for acute exacerbations of mild plaque psoriasis. It is also a requirement of the Secretary Approval: Community Pharmacist Statewide Pilot that pharmacists have completed the designated pharmacist training requirements specified in the departmental guidance before supplying the Schedule 4 poisons.

Pharmacists authorised to supply Schedule 4 poisons under the Regulations must:

- Operate at all times in accordance with the *Drugs, Poisons and Controlled Substances Act 1981*, the Regulations and all other applicable Victorian, Commonwealth and national laws.
- At all times act in a manner consistent with the Pharmacy Board of Australia's (the Board) Code of Conduct and in keeping with other professional guidelines and policies as set out by the Board as applicable.

Pharmacists are also expected to exercise professional judgment in adapting treatment guidelines to presenting circumstances.

1.1. DEFINITIONS AND ACRONYMS

DLQI: Dermatology life quality index

HCP: Healthcare practitioner

HPI-I: Healthcare Provider Identifier-Individual number

MHR: My Health Record

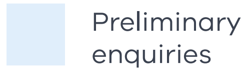
PASI: Psoriasis area and severity index

LPC: Liquor picis carbonis (also known as coal tar solution)

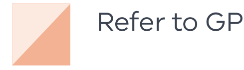
TCS: Topical corticosteroids

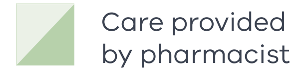
2. Protocol for Management of Acute Exacerbation of Mild Plaque Psoriasis

2.1. KEY TO COLOURS USED IN THIS PROTOCOL


Preliminary enquiries

Immediate referral


Refer to GP


Care provided by pharmacist

Is the patient aged ≥ 18 years?

- No → **Refer to General Practitioner**
- Yes ↓

Has the patient previously been diagnosed by a medical practitioner with mild plaque psoriasis of the trunk or limbs?

- No → **Refer to General Practitioner**
- Yes ↓

Has the patient's psoriasis, including the initial diagnosis and at least one acute exacerbation been successfully managed with topical corticosteroids (TCS) by a medical practitioner?

- No → **Refer to General Practitioner**
- Yes ↓

Does the patient consent?*

- No → **Refer to General Practitioner**
- **Yes: continue to page 4**

*The patient must be physically present in the pharmacy.

Continued from page 3

CONDUCT CLINICAL REVIEW

Examination

1. Confirm signs and symptoms including defined raised red, scaly patches, silvery-white scales of skin which shed or flake, dry, cracked skin that may bleed, itching and pain. Patches are typically symmetrical.
2. Complete assessment of severity using PASI and/or DLQI calculator.

Moderate to Severe → **Refer to General Practitioner and consider seeking specialist referral where appropriate**

Mild ↓

Patient history

1. medication history including TCS used previously for psoriasis, and any new medications
   - review MHR as necessary, where possible/available
2. medical history including complications, pregnancy and/or breastfeeding
3. aggravating factors
4. psychological impact

Does the patient report / present with any of the following?

- ☐ The patient has psoriatic comorbidities or risk factors that require management by a medical practitioner e.g., arthritis, risk of venous thromboembolism, depression, increased alcohol consumption, signs of lymphoma, skin cancers and solid tumours
- ☐ The patient has not seen a medical practitioner for review of their psoriasis in the previous 12 months

Yes → **Refer to a medical practitioner**

→ **Pharmacotherapy by pharmacist** may still be considered if clinically appropriate

→ go to: **PHARMACOTHERAPY** section on page 6 below.

No: continue to page 5

Continued from page 4

Do any of the following apply?

- ☐ The diagnosis is unclear
- ☐ Patient is very visibly unwell
- ☐ The patient is immunocompromised due to underlying medical condition(s) and/or medications
- ☐ The patient has other medical conditions such as diabetes or psoriatic arthritis where referral to a rheumatologist may be required
- ☐ The patient is pregnant or planning a pregnancy
- ☐ The patient presents with a type of psoriasis other than mild plaque psoriasis
- ☐ The psoriasis is moderate (PASI 6–10 and/or DLQI 6–10) or severe (PASI >10 and/or DLQI >10), including if it is having a marked negative emotional and social effect on the person
- ☐ The face, scalp, genitals, palms and/or soles are affected
- ☐ Psoriasis covers a significant body surface area (affects more than 6% of the body)
- ☐ Psoriatic lesions are infected or show pustulation (less defined red plaques with scale and pus)
- ☐ The patient is taking a medicine that can exacerbate, especially lithium, beta-blockers and nonsteroidal anti-inflammatory drugs
- ☐ Inadequate response to topical treatment

Yes

Refer to General Practitioner and consider seeking specialist referral where appropriate

No: continue to page 6

Continued from page 5

PHARMACIST CARE

PHARMACOTHERAPY

Does the patient have allergies, drug-drug interactions or any other contraindications to management options?

Yes

Where therapy is considered the appropriate treatment option but all recommended treatments under this protocol are contraindicated, **refer patient to a medical practitioner**

No

Provide treatment, where indicated*

- Resupply of TCS preparation that patient has used previously for their psoriasis and is available under the pilot (see Section 6 for list of medicines that can be supplied under this pilot)

Dispense medications via pharmacy dispensing software and label according to the legislative requirements outlined in the Drugs, Poisons and Controlled substances Regulation 2017

*Note that while liquor picis carbonis (LPC, or coal tar solution) +/- keratolytics (e.g., salicylic acid) and calcipotriol are also treatment options for psoriasis, these have not been included for supply and reimbursement in the pilot, which has focused on the resupply of prescription only topical corticosteroids.

Provide non-pharmacological and self-care advice

1. Provide patient with Consumer Medicines Information and/or a Self-Care Fact card to help patients control their plaque psoriasis
2. Provide advice on preventing flare-ups i.e., flare-ups can be triggered by stress, cold weather, dry skin, certain foods or drinks
3. Keep skin moisturised using a soap-free cleanser or wash and apply fragrance-free moisturiser

Continue to page 7

Continued from page 6

Communicate agreed treatment plan:

- How to use
  - Counselling including fingertip units for topical corticosteroids and adverse effects
  - Patient resources and information
- Duration of treatment and expectations around duration of symptoms
- General measures:
  - Lifestyle modification
  - Adjunctive agents
- General advice:
  - Expected duration for response to treatment and instructions for withdrawal of TCS
  - Adverse effects
- Communicate with other health practitioners (if required), including referral to medical practitioner if:
  - Patient is not responding to treatment; and/or
  - Symptoms worsen after commencing treatment; and/or
  - Patient is experiencing adverse effects that cannot be managed in the pharmacy setting
- Reminder that review by a medical practitioner recommended to occur at least every 12 months

Document the consultation and share a record of the service with the patient, patient's usual treating GP or medical practice where the patient has one

3. Clinical Documentation Requirements

The pharmacist must make a clinical record of the consultation that contains:

- Sufficient information to identify the patient
- Date of treatment
- Name of the pharmacist who undertook the consultation and their Healthcare Provider Identifier-Individual (HPI-I) number
- Consent given by the patient regarding: pilot participation, costs, pharmacist communication with other healthcare practitioners (e.g. patient's usual treating GP) and access to the patient's My Health Record for the purpose of checking inclusion/exclusion criteria and uploading information relating to the consultation as required
- Any information known to the pharmacist that is relevant to the patient's diagnosis or treatment (including TCS preparations used previously to treat psoriasis and associated flare-ups) and any observations and assessments including allergies and adverse drug reactions
- Any clinical opinion reached by the pharmacist.
- Actions and management plan taken by the pharmacist (including any medications supplied or referrals made to a medical practitioner)
- Particulars of any medications supplied to the patient (such as form, strength and amount)
- Information or advice offered to the patient in relation to any treatment proposed by the pharmacist who is treating the patient

The pharmacist must share a copy of the record of the service with the patient and, if the patient consents, with the patient's usual treating medical practitioner or medical practice, where the patient has one.

The pharmacist must make a record in the pharmacy software and an IT system approved by the Victorian Department of Health, regarding the supply.

Supplementary information

The supplementary information below provides additional guidance and information to Victorian pharmacists participating in the Community Pharmacist Statewide Pilot (the Pilot). It is intended to be used together with the guidelines and other resources referred to here to assist pharmacists in adhering to the management protocol and facilitate delivery of a safe and high quality service to the community for the management of acute exacerbation of mild plaque psoriasis.

4. Assess patient needs

4.1. PATIENT HISTORY

Sufficient information must be obtained from the patient to assess the safety and appropriateness of any recommendations and medicines for the patient.

Consider:

- age
- pregnancy and lactation status, including patients planning pregnancy (if applicable)
- onset, duration, nature, location, severity and extent of plaques and other symptoms
- previous diagnosis and history of exacerbation(s) of plaque psoriasis
- co-existing and underlying medical conditions, including psoriatic comorbidities such as arthritis or depression
- response to any previous treatments
- impacts on quality of life and psychosocial wellbeing
- exposure to factors that can aggravate psoriasis (see table 1)
- current, recently commenced or recently ceased medications (including prescribed medicines, vitamins, herbs, other supplements and over-the-counter medicines)
- family history of psoriasis
- drug allergies/adverse drug effects

Table 1. Factors that can aggravate psoriasis

• streptococcal tonsilitis (strep throat) and other infections • skin trauma and injuries such as cuts, abrasion, sunburn • sun exposure (although gentle exposure is often beneficial • dry skin • obesity • metabolic factors (calcium deficiency) • smoking	• excessive alcohol consumption • hormonal factors (pregnancy or postpartum) • medicines such as lithium, beta-blockers, antimalarials, nonsteroidal anti-inflammatories, antibiotics, ace inhibitors, TNF-α inhibitors • stopping oral steroids or potent topical corticosteroids (TCS) • other environmental factors such as stressful event

4.2. 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.
- In darker skin tones, plaques are generally darker or violet in colour, thicker, and with more obvious scale and itch.
  - Psoriasis Area and Severity Index (PASI) scores may be underestimated in people with darker skin tones.
- Nail changes, include 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 infection. **Note**: As this is not in scope for the Pilot, referral to a medical practitioner is required if nail involvement is identified.

Assessment of severity

- A Psoriasis Area and Severity Index (PASI) score and Dermatology Life Quality Index (DLQI) score should be used to assess severity and responses to treatment.
- PASI calculator and other resources to assist clinicians are included in the *Pharmacist resources* section of this protocol.
- Mild plaque psoriasis = a PASI ≤ 5 and/or DLQI ≤ 5.
- Moderate plaque psoriasis = a PASI 6–10 and/or DLQI 6–10.
- Severe plaque psoriasis = PASI >10 and/or DLQI >10.
  - The psoriasis is always considered severe when the DLQI score is >10, regardless of the PASI score.
  - It may also be considered severe if it has significant impacts on the person's quality of life, due to involvement of visible areas, major parts of the scalp, genitals, palms and/or soles, onycholysis of at least 2 fingernails or pruritus leading to excoriation.

Refer to a medical practitioner when:

Pharmacists must refer patients to a medical practitioner if:

- The diagnosis is unclear
- Patient is very visibly unwell
- The patient is immunocompromised due to underlying medical condition(s) and/or medications
- The patient has other medical conditions such as diabetes or psoriatic arthritis where referral to a rheumatologist may be required
- The patient is pregnant or planning a pregnancy
- The patient presents with a type of psoriasis other than mild plaque psoriasis
- The psoriasis is moderate (PASI 6–10 and/or DLQI 6–10) or severe (PASI >10 and/or DLQI >10), including if it is having a marked negative emotional and social effect on the person
- The face, scalp, genitals, palms and/or soles are affected
- Psoriasis covers a significant body surface area (affects more than 6% of the body)
- Psoriatic lesions are infected or show pustulation (less defined red plaques with scale and pus)
- The patient is taking a medicine that can exacerbate, especially lithium, beta-blockers and nonsteroidal anti-inflammatory drugs
- Inadequate response to topical treatment

5. Management and treatment plan

Pharmacist management of acute exacerbation of mild plaque psoriasis involves:

General management:

- Education and advice regarding lifestyle modification, use of adjunctive agents and other measures as per [Psoriasis [2022 August] In: *Therapeutic Guidelines*].
- Self-care advice to prevent flares:
  - Avoid using soaps, which can dry and irritate the skin. Use a soap-free cleanser.
  - Avoid scratching. Keep fingernails and toenails short.
  - Flare-ups can be triggered by stress, cold weather, dry skin, certain foods, or drinks.

Pharmacotherapy

- Topical treatments in accordance with [Psoriasis [2022 August] In: *Therapeutic Guidelines*].

NB1: Topical preparations containing LPC and/or salicylic acid (in dermal preparations containing <40% salicylic acid) are also a treatment option for psoriasis and may be sold without a prescription. These have not been included in the pilot however, which has focused on the resupply of prescription only TCS.

NB2: TCS are the mainstay of treatment for psoriasis flare. If topical treatment with class I-III TCS does not produce an adequate response to the acute exacerbation, the patient should be referred to a medical practitioner for management.

5.1. CONFIRM MANAGEMENT IS APPROPRIATE

Pharmacists must consult the *Therapeutic Guidelines*, Australian Medicines Handbook and other relevant references to confirm the treatment recommendation is appropriate, including for:

- Contraindications and precautions
- Drug interactions
- Pregnancy and lactation

5.2. COMMUNICATE AGREED MANAGEMENT PLAN

Comprehensive advice and counselling (including supporting written information when required) as per the Australian Medicines Handbook and other relevant references should be provided to the patient regarding:

- The typical cycle of psoriasis and the expectations of treatment
- Product and medication use:
  - Dosing and application instructions for TCS, moisturisers, emollients and other topical products
- How to manage adverse effects
- When to seek further care and/or treatment, including recognising infection
- When to return to the pharmacist for clinical review

It is the pharmacist's responsibility to ensure the suitability and accuracy of any resources and information provided to patients, and to ensure compliance with all copyright conditions.

5.2.1 General advice

- Where appropriate, individuals may be provided with additional resources to support self-management of psoriasis. Factsheets and other information suitable for patients on psoriasis include:
  - Better Health Channel 'Psoriasis': Psoriasis – Better Health Channel
  - NPS MedicineWise factsheets:
    - Topical treatments for your plaque psoriasis
    - Plaque psoriasis: my options when topical treatments aren't enough
- Patients should be advised that each new treatment may take time to work and should be trialled for 2 to 4 weeks. However, adequate response to optimal topical treatment may take up to 3 to 6 months to be achieved.
- If a good response has been achieved, advise the patient to reduce the frequency of TCS application until stopped. The patient can resume their usual management plan. If they experience a further acute exacerbation (flare up) of their psoriasis they can seek another psoriasis consult (for the duration of the Victorian Pilot).
- The patient should be advised to immediately see their medical practitioner if symptoms worsen after commencing treatment.
- Common adverse effects of TCS, such as transient burning, stinging or pain on application, can generally be reversed by stopping the medicine.
  - Referral to a medical practitioner is required when adverse effects cannot be managed in the pharmacy setting.
- All patients should be advised to contact a medical practitioner if:
  - They are not responding to treatment; and/or
  - Their condition worsens; and/or
  - They are experiencing complications (as soon as the complications become evident)
- Patients should be advised that review by a medical practitioner is recommended to occur at least every 12 months.

6. Medicines

The Pilot authorises the supply of certain topical corticosteroids for the treatment of acute exacerbation of mild plaque psoriasis where these are indicated.

Note: There are no changes to the scope for pharmacists to supply Schedule 2 and 3 topical corticosteroids and so these are excluded for reimbursement for the purposes of this pilot.

Treatment for acute exacerbation of mild plaque psoriasis*

Moisturisers

- Useful adjunct to other treatments as moisturisers hydrate the skin, soften scaling and reduce itching and irritation.
- Encourage regular use of moisturisers, particularly after bathing or showering, to reduce water loss from the skin. Advise use of emollient soap substitutes or fragrance-free bath oils.

Topical Corticosteroids	Strength	Dose	Preparations	Brand name examples
Moderate Corticosteroids [NB1] [NB2]				
Betamethasone valerate	0.02%	1 or 2 times a day	cream, 2x100g	Antroquoril, Betnovate 1/5, Celestone-M, Cortival 1/5
Betamethasone valerate	0.05%	1 or 2 times a day	cream, 1x15g or 1x30g	Betnovate 1/2, Cortival 1/2
Triamcinolone acetonide	0.02%	1 or 2 times a day	cream, ointment, 2x100g	Aristocort, Tricortone
Potent Corticosteroids [NB1] [NB2]				
Betamethasone dipropionate	0.05%	1 or 2 times a day	cream, 1x15g ointment, 1x15g lotion, 1x30mL	Diprosone, Eleuphrat
Betamethasone valerate	0.1%	1 or 2 times a day	cream, ointment, 1x30g	Betnovate
Methylprednisolone aceponate	0.1%	Once a day	cream, ointment, fatty ointment, 1x15g lotion, 1x20g	Advantan
Mometasone furoate	0.1%	Once a day	cream, ointment, 1x50g lotion, 1x30mL	Elocon, Momasone, Novasone, Zatamil

* Adapted with permission from: Considerations in the use of topical corticosteroids [published 2022 August]. In: Therapeutic Guidelines. Melbourne: Therapeutic Guidelines Limited; accessed 12 December 2023. https://www.tg.org.au

NB1: Potency classification for each drug is based on the results of vasoconstrictor studies. Potency classifications based on vasoconstrictor effect typically correlate with therapeutic potency; however, many other factors determine therapeutic potency in a patient (eg area of application, frequency and duration of treatment).

NB2: Formulation of a drug can affect potency; a topical drug prepared as a cream is less potent than the same drug prepared as an ointment.

7. Resources for pharmacists

Guidelines

Dermatology [2022 August]. In: *Therapeutic Guidelines*. Melbourne: Therapeutic Guidelines Limited; accessed November 2023. https://www.tg.org.au Relevant topics are Psoriasis and Considerations in the use of topical corticosteroids.

Australian Medicines Handbook:

- Drugs for psoriasis
- General principles: topical treatment of skin conditions
- Corticosteroids
- Topical steroids – how much do I use?

MSD Manual (Professional version) – Psoriasis

DermNet NZ:

- PASI score
- Psoriasis

Cardiff University: Dermatology of Life Quality Index

The Australasian College of Dermatologists:

- Consensus statement: Treatment goals for psoriasis
- A-Z of skin – psoriasis
- Taking care of skin: How to recognise and respond to skin health issues in Aboriginal and Torres Strait Islander peoples
- Consensus statement: Topical corticosteroids in paediatric eczema (see table 1 page 4 for TCS preparation potency ranking)

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 – slide show: common skin rashes

Professional Practice Standards

https://www.psa.org.au/practice-support-industry/pps/

Patient Information

Better Health Channel 'Psoriasis':

- Psoriasis – Better Health Channel

NPS MedicineWise factsheets:

- Topical treatments for your plaque psoriasis
- Plaque psoriasis: my options when topical treatments aren't enough

Psoriasis Australia website

ACKNOWLEDGEMENT

This protocol has been adapted from the draft Clinical Practice Guideline *Acute Exacerbations of Mild Plaque Psoriasis* from Queensland Health.

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