PHARMACIST ASSESSMENT – Onychomycosis

Patient		
Name:	HSN:	
Address:	DOB:	☐ male ☐ female
Telephone:	☐ Pregnant ☐ Lactating	

Medical History:

☐ Previously diagnosed with onychomycosis by a physician, nurse practitioner or podiatrist → refer if no prior diagnosis

☐ Immunocompromised from condition or medication → refer

☐ Other conditions which can cause nail deformities, eg. Hypo-/hyperthyroidism, iron deficiency → consider alternate diagnosis

Drug History:

☐ Diabetes or peripheral vascular disease → refer

☐ Drug which has been implicated in nail disorders, eg. cancer chemotherapy, gold therapy, antimalarial agents, psoralens, retinoids, thyroid hormones, tetracyclines → consider alternate diagnosis

Review of Symptoms

Any red flags present?

☐ Current symptoms are likely from a previous infection that did not fully clear despite appropriate treatment

☐ All or most nails involved

☐ More than 50% of individual nail(s) involved, or separation from nailbed

☐ Yes to any → refer for consideration of oral antifungal treatment

Are there additional risk factors for onychomycosis?

☐ Tinea pedis (athlete's foot) infection

☐ Psoriasis of the skin

☐ Participates in sports that involve bare feet

☐ Wears occlusive footwear

☐ Smokes tobacco

☐ Age > 65 years

☐ Yes to any → Increased likelihood that patient's diagnosis of OM is correct

Are symptoms consistent with diagnosis of onychomycosis?

☐ Thickened, white to yellow discoloration of distal and lateral edges of nail(s)

☐ Separation of nail from nailbed

☐ Brittle, crumbling nail plate

☐ Yes → Continue ☐ No, consider other conditions – treat / refer as appropriate

Has the patient tried any non-pharmacologic or pharmacologic treatment for onychomycosis?

☐ No ☐ Yes → What? Effect?

Treatment

Non-pharmacologic treatment AND

☐ Non-prescription topical
Propylene glycol/urea/lactic combination OR

☐ Prescription topical
Efinaconazole 10% solution
Apply 1 drop to affected toenail (2 drops if big toenail) once daily
Mitte: 6 ml. Refill as needed for up to 48 weeks

☐ Treatment of contributing comorbidities such as *Tinea pedis* (See *Tinea pedis* guideline)

☐ Referral to MD for management of contributing comorbidities such as diabetes, peripheral vascular disease

Prescription Issued

Rationale for prescribing:

Rx: Efinaconazole 10% solution

Quantity: 6 ml. Refill for up to 48 weeks

Directions: Apply once daily to affected nails
pseudoDIN 00951324

Counseling ☐ May have prescription filled at pharmacy of choice ☐ PAR will be communicated to primary care provider as part of collaborative practice

☐ General measures
☐ Appropriate application technique
☐ Slow onset of effect, duration of therapy
☐ If no improvement after 6 to 8 weeks , or if symptoms worsen, refer

Follow-up scheduled in 60 days (date):

☐ Assess for improvement of symptoms
☐ Assess for new symptoms e.g. cellulitis, paronychia
☐ If worsening or no improvement, refer
☐ If improving, encourage ongoing treatment – may take up to 48 weeks

Prescribing Pharmacist:

Name:	Signature:
Pharmacy:	Telephone:
	Fax:
Email:	Date:
Primary Care Provider:	**Fax:**

Pharmacist Minor Ailment Prescribing Record

To

This document is to inform you I met with your patient below who presented with **onychomycosis.** After an assessment, a prescription was issued for

The prescription details and rationale for my decision are documented below. This is for your information to keep your records for this patient up to date.

Patient Demographics:

Name:	HSN:	☐ male ☐ female
Address:	DOB:	
Telephone:	□ Pregnant □ Breastfeeding	

Prescription Issued on _____

MEDICATION: Efinaconazole 10% solution

DIRECTIONS: Apply once daily to affected toenails

QUANTITY: 6ml, refill up to 48 weeks

Rationale for prescription / relevant patient information:

I will follow-up with the patient on _____ and discuss these items:

☐ Assess for improvement of symptoms
☐ Assess for new symptoms e.g. cellulitis, paronychia
☐ If worsening or no improvement, refer
☐ If improving, encourage ongoing treatment – may take up to 48 weeks

Prescribing Pharmacist:

Name:	Signature:
Pharmacy:	Telephone:
Email:	Fax:

Primary Care Provider notified:

Name:	Fax: