PHARMACIST ASSESSMENT – ERECTILE DYSFUNCTION

Patient	
Name:	HSN:
Address:	DOB: ☐ < 18 years of age → Refer ☐ > 65 years of age → Consider initial dose reduction
Telephone:	
Liver function: ☐ Normal ☐ Impaired à lower dose of PDE-5 inhibitor may be indicated	Renal function: ☐ Normal ☐ Impaired: CrCL = _____ à lower dose of PDE-5 inhibitor may be indicated

Medical History:

Prior assessment by NP or MD, diagnosis of erectile dysfunction

☐ **Yes** à **Continue** ☐ **No** à **Refer**

Medical condition(s) which could cause or contribute to ED (See guideline for more details)

- ☐ Diabetes
- ☐ Hypertension
- ☐ Dyslipidemia
- ☐ Peripheral vascular disease
- ☐ Coronary artery disease (including recent myocardial infarction, heart failure, arrhythmias)
- ☐ Lower urinary tract symptoms (LUTS)
- ☐ Neurological condition (multiple sclerosis, Parkinson's, spinal cord injury, etc.)
- ☐ Mental health conditions (anxiety, depression, etc.)
- ☐ Other _____ _____ _____ _____
  - ☐ None à Continue
  - ☐ Yes to any, but treated and stable à Continue
  - ☐ Yes to any, NOT treated *or* treated but NOT stable à Refer

Drug History/ Drug allergies:

Nitrates (Contraindicated with PDE-5 Inhibitors)

☐ Yes à Refer

Alpha-blocker therapy (especially terazosin, doxazosin)

☐ Yes à Start PDE-5 inhibitor at lowest dose

CYP3A4 inhibitor à (Name of drug) _____

☐ Consider alternative, prescribe lowest dose or increase interval between doses of PDE-5 inhibitors

Medication(s) which could cause or contribute to ED (See guideline)

- ☐ Yes à (Name of drug) _____ _____
- ☐ Initiation of drug, dose increase correlates with emergence of ED symptoms → Consider dose reduc on, discontinuation, alternative therapy and/or refer

Previous treatment for ED:

- ☐ Yes à (Name of drug) _____ _____Effect: _____ _____ _____
- ☐ No à Investigate reason for not treating, consider referral

Other relevant medication(s) :

Review of Symptoms

Has there been any trauma to genital area, pelvis or spine since ED diagnosis?

☐ No à Continue ☐ Yes à Refer

Is lack of libido a primary complaint?

☐ No à Continue ☐ Yes à Refer

Are there concerns with ejaculatory dysfunction (eg. premature, delayed, or inhibited?)

☐ No à Continue ☐ Yes à Refer

Inability to achieve and maintain penile erection for satisfactory intercourse ≥ 75 % of attempts for ≥ 3 months?

☐ No à Pharmacologic treatment not indicated ☐ Yes à Continue to treatment

Treatment

☐ Non-pharmacologic therapy

Discuss lifestyle risk factors as applicable

☐ PDE-5 inhibitors

- ☐ Sildenafil 25, 50, 100 mg tablets PRN (Maximum 100 mg/24 hrs)
- ☐ Tadalafil 2.5, 5, 10, 20 mg tablets PRN (Maximum 20 mg/36 to 48 hrs)
- ☐ Vardenafil 5, 10, 20 mg film-coated tablets PRN (Maximum 20 mg/24 hrs)
- ☐ Vardenafil 10 mg oral disintegrating tablets PRN (Maximum 10 mg/24 hours)

Prescribe lowest available dose initially if over 65 years of age, renal dysfunction, hepatic dysfunction, concurrent CYP3A4 inhibitor therapy, concurrent a-blocker therapy

Prescription Issued for minor ailment

Rationale for prescribing:

Rx:

Quantity: 4 or 6 tabs (Refill for 12 months)

Directions:

pseudoDIN 00951320

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

☐ Non-pharmacologic management

☐ Time to onset, sexual stimulation required for effect, duration of effect

☐ Side effects requiring medical attention such as chest pain, priapism, visual disturbances

Follow-up scheduled in 2 to 4 weeks :

☐ **In pharmacy** ☐ **Telephone**

☐ Effect satisfactory – continue use

☐ Effect not satisfactory – assess patient understanding of how to use the medication, number of attempts, and/or recommend increased dose if appropriate

☐ No success with highest dose after at least 4 attempts, refer

☐ Assess for side effects

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 **erectile dysfunction** which has previously been diagnosed. 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:
Address:	DOB:
Telephone:	

Prescription Issued on _____

MEDICATION:

DIRECTIONS:

QUANTITY:

Rationale for prescription / relevant patient information:

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

☐ Effect satisfactory – continue use
☐ Effect not satisfactory – assess patient understanding of how to use the medication, number of attempts, and/or recommend increased dose if appropriate
☐ No success with highest dose after at least 4 attempts, refer
☐ Assess for side effects

Prescribing Pharmacist:	
Name:	Signature:
Name of Pharmacy:	Telephone:
Email:	Fax:

Primary Care Provider notified:	
Name:	Fax: