

PHARMACIST ASSESSMENT – MILD ACNE

Patient information <input type="checkbox"/> Informed consent obtained <input type="checkbox"/> PharmaNet Check <input type="checkbox"/> Patient Eligible		
Name:	PHN:	DOB: <small>(refer <12)</small>
Address:	<input type="checkbox"/> Allergies:	
Telephone:	<input type="checkbox"/> Pregnant	<input type="checkbox"/> Breastfeeding/Chestfeeding
Medical History: <input type="checkbox"/> Family history of scarring acne → refer <input type="checkbox"/> Previous diagnosis of acne → helps confirm patient self-diagnosis		
Drug History: <input type="checkbox"/> On medication that could cause or worsen acne (see guideline for list) → refer		
Review of Symptoms:		
Any red flag symptoms present? <input type="checkbox"/> Alarm signs or symptoms (fever or arthralgia, hyperandrogenism [eg. scalp hair loss, facial hair]) <input type="checkbox"/> Approximately more than 20 comedones present <input type="checkbox"/> Approximately more than 15 inflammatory papules present <input type="checkbox"/> Total lesion count greater than 30 <input type="checkbox"/> Erythema, papules, pustules in the absence of comedones (other conditions must be ruled out) <input type="checkbox"/> Widespread inflammatory lesions (i.e. involving areas beyond the face) <input type="checkbox"/> High levels of anxiety, low self-esteem <input type="checkbox"/> Unable to confirm patient self-diagnosis <input type="checkbox"/> New onset age > 30 <div style="margin-left: 40px;"> <input type="checkbox"/> Yes to any → Refer <input type="checkbox"/> No → Continue </div>		
Are symptoms typical of mild acne? <input type="checkbox"/> Comedonal acne (white & blackheads and no inflamed lesions) <input type="checkbox"/> Mild inflammatory acne (papules, pustules) <input type="checkbox"/> No nodules or cysts <div style="margin-left: 40px;"> <input type="checkbox"/> Yes → Continue <input type="checkbox"/> No → Consider alternate diagnosis/ refer </div>		
Symptom Review Summary		
<input type="checkbox"/> Appropriate to proceed with minor ailment treatment <input type="checkbox"/> Advised to see another health care provider as out of scope		
Treatment:		
Has the patient been practicing optimal skin care? <input type="checkbox"/> Yes → Continue <input type="checkbox"/> No → Include skin care education in treatment plan and continue		
Choose one of the following options based on patient symptom(s): <input type="checkbox"/> 1: Prescribe topical retinoid		

- ☐ 2: Prescribe topical benzoyl peroxide (BP)
- ☐ 3: Prescribe combination therapy or product
- ☐ 4: Other:

If patient has previously tried a therapy above and has had unsatisfactory improvement after 8 – 12 weeks :

- ☐ Switch to different topical class (e.g. switch from BP to retinoid) OR
- ☐ Add a different topical class (e.g. antibiotic, retinoid, etc.) OR
- ☐ Consider a combination product (e.g. clindamycin/BP, adapalene/BP, etc.)

Prescription Issued for Minor Ailment ☐

Diagnosis:

Rx:

Quantity:

Dosage directions:

Other Recommendations (e.g., OTC, self-care, referral to other healthcare provider):

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

- ☐ Patient may see initial worsening for the first 2 to 4 weeks
- ☐ May take 8 – 12 weeks for maximum benefit
- ☐ Provide method for gradual titration of application time to reduce skin irritation
- ☐ Possible adverse effects associated with prescribed product

Follow-up plan (recommended in 8 weeks):

- ☐ **Patient's acne has responded well** → Continue
- * For patients who have responded well to benzoyl peroxide or a topical retinoid, maintenance regimen may be continued indefinitely.
 - * Topical antibiotics should be discontinued after resolution of inflammatory symptoms.
- ☐ **No, or unsatisfactory response, but acne is not worse** → switch classes, add a class or change to a combination product.
- ☐ **Discontinued therapy due to adverse effects** → Reassess (e.g. adjust titration schedule if too aggressive), consider alternate treatments (as above) and / or refer (as above)
- ☐ **Patient's acne has worsened** → Refer

Prescribing Pharmacist and Pharmacy Information:

Pharmacist Name:	Pharmacist License Number:
Pharmacy Name:	Pharmacy Address:
Signature:	Date:
Telephone:	Fax:

Provider Notified (if applicable)

Primary care provider (name):	Date, Method Notified:
Other Health Care Providers:	Date, Method Notified:

Pharmacist Minor Ailment Prescribing Record

To This document is to inform you I met with your patient below who presented with mild acne . 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:	PHN:
Address:	DOB:
Telephone:	<input type="checkbox"/> Pregnant <input type="checkbox"/> Breastfeeding/Chestfeeding
Prescription Issued on MEDICATION: DIRECTIONS: QUANTITY:	
Rational for prescribing/ relevant patient information:	
I will follow-up with the patient on _____ and discuss these items:	
<input type="checkbox"/> Patient's acne has responded well → May issue refills for up to 6 months total duration. * For patients who have responded well to benzoyl peroxide or a topical retinoid, maintenance regimen may be continued indefinitely. * Topical antibiotics should be discontinued after resolution of inflammatory symptoms. <input type="checkbox"/> No, or unsatisfactory response, but acne is not worse → switch classes, add a class or change to a combination product. <u>*Maximum of two product trials before referral required.</u> <input type="checkbox"/> Discontinued therapy due to adverse effects → Reassess (e.g. adjust titration schedule if too aggressive), consider alternate treatments (as above) and / or refer (as above) <input type="checkbox"/> Patient's acne has worsened → Refer	
Prescribing Pharmacist and Pharmacy Information	
Pharmacist Name:	Pharmacist License Number:
Pharmacy Name:	Pharmacy Address:
Signature:	Date:
Telephone:	Fax:
Providers Notified (if applicable)	
Primary Care Provider (name):	Date, Method Notified:
Other Health Care Provider:	Date, Method Notified: