



College of Pharmacists of Manitoba Special General Meeting

Monday, June 19, 2017

St. Boniface Research Centre

351 Tache Avenue, Winnipeg, Manitoba

6:45 p.m. Registration

7:00 p.m. – 9:00 p.m. Meeting

The College will be hosting a meeting on Monday, June 19, 2017, convening at 7:00 p.m. at the St. Boniface Research Centre with pharmacists, pharmacy technicians and other stakeholders invited to participate in discussions regarding the topics outlined in the agenda below.

This meeting will take the format of a Council update on each agenda item followed by an opportunity for members to discuss the item. Recommendations expressed at the meeting will be forwarded to Council for further consideration.

A G E N D A

CHAIR – Jennifer Ludwig, President of CPhM

1. Convene – 7:00 p.m.
President Jennifer Ludwig
2. Pharmacist prescriptive authority for Self-Limiting Conditions:
Consideration of additional conditions to be added and the regulation consultation and amendment process required
3. Governments Legislative Proposal to Amend Section 74 of *The Pharmaceutical Act* regarding member approval of regulations
 - a. Member support survey response (84.25% in support, 15.75% in opposition)
 - b. Next steps
4. Open Discussion – Jennifer Ludwig, President
 - a. Update on the expanded review and consultation process for the draft “Practice Direction: Distance Care”
 - b. Topics from the members
5. Adjourn – 9:00 p.m.

The evening’s program will be accredited for 2 CEU.

Videoconference Sites:

Not all locations are available for all programs/meetings. Please contact the College office to confirm the availability of your selected site.

For a complete listing of videoconference site locations, click [here](#).

Live Webcasting:

In addition to live webcasting, this program will be recorded and posted on the sbrstream.ca website. For instructions on webcasting, click [here](#). Members must fill out an evaluation form in order to receive accredited CEU for live webcasting.

Register to the College by calling 204.233.1411 or emailing rsvp@cphm.ca.

The College of Pharmacists of Manitoba Rules of Procedure

1. A Notice of Meeting will be forwarded to the entire membership no less than twenty-one (21) days prior to the scheduled meeting.
2. A quorum is required to convene a meeting and to transact any business. A quorum must be at least 5% of the voting members in attendance.
3. A Parliamentarian will assist with parliamentary procedure as the need arises.
4. Robert's Rules of Order will govern.
5. The Chair of the general meeting may permit discussion of motions that are for information and do not require action by the College. Motions, either simple or by resolution, accepted at an annual general meeting, or a special general meeting, requiring action on behalf of the College shall be forwarded to Council for consideration and decision.
6. All voting members must sign the attendance sign-in sheet.
7. Voting cards will be issued to all voting members.
8. All members and Council members may speak only once to any given resolution and debate may be limited, unless permission to the contrary is given by the assembly.
9. All persons wishing to address the meeting are requested to speak at the microphone and are further requested to identify themselves by name before speaking.
10. The Mover and Seconder can speak first, followed by other speakers. The Mover has the option of being the last speaker to the motion.
11. Speakers must address the chair.
12. All members present are encouraged to engage in discussion, but only voting members and Council members may make motions and vote.
13. The members of the College consist of the persons whose names are on the register and who have paid the fees prescribed in the bylaws.
14. Every member who is a licensed pharmacist and members of Council are entitled to vote at a meeting of the College.
15. Non-members and observers are welcome to attend, but are unable to engage in discussion or vote.
16. Motion forms will be provided. Motions should be in writing on these forms and the appropriate copy given to the Chair at the time of making the motion.

Clarification:

- Only licensed pharmacists and Council members have the right to vote; however, all members who are on the College register and have paid a fee for the current year can speak, but not vote.
- Regarding the right to speak at meetings of the College, Robert's Rules would apply and the voting members (licensed pharmacists with a vote) and Council members attending the meeting would decide in each incident whether or not an attendee at the meeting would have the right to speak.

Discussion Document on Pharmacist Prescribing



Part I: Rationale for recommendations made by the ad-hoc committee on self-limiting conditions

Part II: Consideration of a new category of pharmacist prescribing when an assessment and diagnosis is made by a physician, nurse practitioner or other designated health professional

Contents

Discussion Document on Pharmacist Prescribing

Introduction	1
Part I.....	3
Environmental Scan	3
Recommendations	4
Suggested Criteria for Self-Limiting Conditions	4
Suggested Criteria for Prescription Drugs Suitable for Pharmacist Prescribing for Patient Self-Limiting Conditions	5
Conditions Considered but not Recommended.....	8
Rationale for Included Conditions	9
Contraception	9
Urinary Tract Infection.....	10
Gastroesophageal Reflux Disease.....	11
Corns, Calluses, and Warts (Excluding Facial and Genital)	12
Dysmenorrhea	13
Emergency Contraception	14
Impetigo.....	15
Folliculitis	16
Herpes Labialis	17
Tinea Cruris	18
Tinea Corporis.....	19
Recurrent Vaginal Candidiasis	20
Pinworms	21
Part II.....	22
Additional Considerations.....	22
Hypertension.....	22
Herpes Zoster.....	23
Allergic conjunctivitis	23
Migraine	23
Erectile dysfunction	23
Onychomycosis	23
Appendix A.....	25
Appendix B	26
Appendix C	27



College of Pharmacists of Manitoba

200 Tache Avenue, Winnipeg, Manitoba R2H 1A7

Phone (204) 233-1411 | Fax: (204) 237-3468

E-mail: info@cphm.ca | Website: www.cphm.ca

Introduction

Under *The 2006 Pharmaceutical Act (The Act)* and accompanying Regulation, pharmacists were granted advanced scope of practice privileges. Expanded prescriptive authority is among these new practices. The Regulation authorizes prescribing by a pharmacist under the following conditions: prescription adaptation, continued care prescriptions, medical devices or non-prescription medications, prescribing in a public health emergency, for conditions listed in Schedule 3 to the Regulation (self-limiting conditions), and under the extended practice pharmacist designation.

As with most pieces of Legislation, there was a large gap of time from when *The Act* and Regulation was developed to when they came into effect. Since then, the practice of pharmacy has continued to evolve. It was identified by the members that the current list of conditions and drugs listed in Schedule 3 to the Regulation (self-limiting conditions; Table 1) was outdated. In comparison to the other provinces, Manitoba has one of the fewest conditions pharmacists are authorized to prescribe for. As such, an ad-hoc committee (Committee) was established for the purpose of reviewing and making recommendations to the Council of The College of Pharmacists of Manitoba (College) for additional self-limiting conditions for which a pharmacist may prescribe.

MOTION #16: MOVED BY GLENDA MARSH, SECONDED BY KEVIN HAMILTON THAT the Council create an ad-hoc committee to review Schedule 3 conditions and the travel health vaccine and medications for which pharmacists can prescribe. The ad-hoc committee will be tasked with completing an environmental scan of other provinces, and will make recommendations to the Executive Committee for consideration before being presented to Council.

CARRIED

From the February 8, 2016, Council meeting, the members of the Committee were established:

MOTION #18: MOVED BY GLENDA MARSH, SECONDED BY KEVIN HAMILTON THAT the members of the ad-hoc committee tasked with reviewing and making recommendations to Council for additional Schedule 3 conditions for which pharmacists may prescribe, are Kevin Hamilton (Chair), Amir Baksh, Drena Dunford (University of Manitoba), Dennis Wong (Pharmacists Manitoba) and Allan Gillis.

CARRIED

*College of Pharmacists of Manitoba Mission:
To protect the health and well being of the public by ensuring and
promoting safe, patient-centred and progressive pharmacy practice.*

Member of the National Association of Pharmacy Regulatory Authorities

Table 1: Drugs and conditions covered under Schedule 3 of the Regulations

SCHEDULE 3
(Subsection 118(2))

**DRUGS THAT A MEMBER MAY PRESCRIBE
(IF TRAINING PROGRAM COMPLETED)**

Condition	Prescription Drug Category (ATC — (anatomic therapeutic chemical classification)
Atopic dermatitis Allergic contact dermatitis Irritant contact dermatitis Urticaria	D07AA: Corticosteroids, weak (group I) D07AB: Corticosteroids, moderately potent (group II)
Acne vulgaris	D10AE01: Benzoyl Peroxide D10AF01: Clindamycin
Tinea pedis	D01AE: Other antifungals for topical use
Candidal stomatitis	A07AA02: Nystatin
Unspecified haemorrhoids without complication	C05AA: Corticosteroids
Vasomotor and allergic rhinitis	R01AD: Corticosteroids R01AX03: Ipratropium Bromide
Seborrhoeic dermatitis (excluding pediatric)	D01AE: Other antifungals for topical use
Recurrent oral aphthae	A01AC: Corticosteroids for local oral treatment
Vomiting of pregnancy, unspecified	R06AA59: Doxylamine, Combinations
Smoking Cessation	N07BA: Drugs used in nicotine dependence

Note: Schedule 3 was amended for the condition “Acne vulgaris” with the addition of the drug “D10AF51: Clindamycin combinations”. Refer to [The Pharmaceutical Act \(C.C.S.M. c. P60\) Pharmaceutical Regulation, amendment. Regulation 136/2016 Registered September 23, 2016](#)

This discussion paper has been prepared for members and stakeholders of the College to:

- Provide the Committee’s reasoning in developing their recommendations to Council on additional self-limiting conditions that may be added to Schedule 3 of the regulation; and,
- Consider additional conditions that may be added to Schedule 3 for which pharmacists may prescribe when an assessment and diagnosis has been made by a physician, nurse practitioner or other designated health professional and the prescribing is done in collaboration with that health care provider.

Part I

Environmental Scan

Each Committee member and additional College staff were assigned a province to review. Upon completion, the Committee then discussed conditions that were not identified that would be appropriate for inclusion. Select U.S. states were also reviewed to obtain additional information. The completed scan can be seen below (Table 2).

Table 2: Authorized conditions for pharmacist prescribing in Canada

Condition	SK	MB	PEI	NS	NB	NL	QU
Acne vulgaris	✓	✓	✓	✓	✓	✓	✓
Allergic conjunctivitis							✓
Allergic rhinitis	✓	✓	✓	✓	✓	✓	✓
Aphthous ulcers	✓	✓	✓	✓	✓	✓	✓
Atopic dermatitis	✓	✓	✓	✓	✓	✓	✓
Caluses and corns			✓	✓	✓	✓	
Candidal dermatitis (diaper dermatitis)	✓						✓
Contact dermatitis		✓	✓	✓	✓	✓	
Cough			✓	✓			
Dandruff			✓	✓	✓	✓	
Diarrhea (non-infectious)			✓	✓	✓	✓	
Dysmenorrhea	✓		✓	✓	✓	✓	✓
Dyspepsia			✓	✓	✓	✓	
Emergency contraception			✓	✓	✓	✓	
Folliculitis	✓						
GERD	✓		✓	✓	✓	✓	
Headache	✓		✓	✓	✓	✓	
Hemorrhoids	✓	✓	✓	✓	✓	✓	✓
Herpes simplex	✓		✓	✓	✓	✓	✓
Impetigo	✓			✓	✓	✓	
Joint pain, mild			✓	✓	✓	✓	
Muscle pain			✓	✓	✓	✓	

Condition	SK	MB	PEI	NS	NB	NL	QU
Musculoskeletal strains and sprains	✓						
Nasal congestion			✓	✓	✓		
Nausea			✓	✓	✓	✓	
Oral candidiasis	✓	✓	✓	✓	✓	✓	✓
Pinworms			✓	✓	✓	✓	
Seborrhoeic dermatitis (except pediatric)		✓					
Sleep disorders			✓	✓	✓	✓	
Smoking cessation		✓	✓	✓	✓	✓	
Sore throat			✓	✓			
Threadworms			✓	✓	✓		
Tinea corporis	✓		✓	✓	✓	✓	
Tinea curis	✓						
Tinea pedis	✓	✓					
Upper respiratory conditions, mild					✓	✓	
Urinary tract infection (uncomplicated)					✓		✓
Urticaria	✓	✓	✓	✓	✓	✓	
Vaginal candidiasis			✓	✓	✓	✓	✓
Vasomotor rhinitis		✓					
Vomiting of pregnancy		✓					
Warts (excluding facial and genital)			✓	✓	✓	✓	
Xerophthalmia			✓	✓	✓	✓	

Recommendations

In reviewing the conditions for inclusion under self-limiting condition prescribing, a standardized definition was needed. It was the consensus of the Committee to adopt the definition of self-limiting condition prescribing used by the University of Saskatchewan¹:

Suggested Criteria for Self-Limiting Conditions

- Can be reliably self-diagnosed by patient
- Self-limiting condition (resolves without treatment)
- Laboratory tests are not required for diagnosis

¹ <https://medsask.usask.ca/professional/guidelines/> Accessed May 24, 2017

- Treatment will not mask underlying conditions
- Medical and medication histories can reliably differentiate more serious conditions
- Only minimal or short-term follow-up needed

Suggested Criteria for Prescription Drugs Suitable for Pharmacist Prescribing for Patient Self-Limiting Conditions

- Has an official indication for the self-care condition
- Has valid evidence of efficacy for the self-care condition
- Has wide safety margin
- Not subject to abuse
- Dosage regimen for treatment of self-care conditions is not complicated

Conditions not included in the final recommendation either did not meet these criteria or pharmacists are already able to prescribe for the condition. To illustrate this, the Committee did not recommend including xerophthalmia (dry eye). First line therapy is lubricating eye drops and lifestyle/environmental changes followed by lubricating ointment. These are available over-the-counter (OTC) and pharmacists are already authorized to prescribe NAPRA Schedule II, Schedule III and unscheduled drugs/products under the regulation. Should a patient fail to achieve relief with these measures, these patients represent a more severe form of dry eye which should prompt a referral to an appropriate health care provider and the condition is no longer considered a *minor* ailment or self-limiting condition.

1. Recommended conditions for which pharmacists may prescribe:

The Committee makes the following recommendations for additional Schedule 3 conditions for which pharmacists may prescribe:

Recommended Conditions	Notes
Calluses, corns and warts	Excluding facial and genital warts
Dysmenorrhea	Non-contraceptive treatments
Emergency contraception	
Impetigo	Non-Bolus - Mild
Folliculitis	
Gastroesophageal reflux disease (GERD)	
Herpes simplex (cold sores)	Recurrent only - topical & oral
Hormonal contraception	
Pinworms/Threadworms	
Tinea corporis	
Tinea curis	
Urinary tract infection	Recurrent, uncomplicated, non-pregnant
Vaginal candidiasis	Recurrent, uncomplicated

2. Recommendations regarding educational requirements:

The Committee recommends that an additional training component should be included in the current self-limiting condition training to encompass the new conditions recommended to Council. The Committee further recommends that the ability of the pharmacist to prescribe for the second group of conditions would require successful completion of an additional Council-approved course.

Rationale:

There are a number of pharmacists who currently have the ability to prescribe for self-limiting conditions. These pharmacists should not be required to undertake the training again, but instead be offered additional training specific to the self-limiting conditions added as part of the qualification and authorization process. The Committee therefore envisioned an additional training component for the additional self-limiting conditions and pharmacists currently authorized to prescribe for self-limiting conditions will be required to successfully undertake this additional training component prior to being authorized to prescribe for the additional self-limiting conditions.

3. Recommendations regarding inclusion of travel health:

The Committee initially recommended to Council that travel health not be included in self-limiting condition prescribing. The Committee understands the extensive training that is required and that travel health should have a separate designation with separate, unique qualifications. For this reason, the Committee further recommended that this be referred to the Extended Practice Pharmacist (EPPh) Advisory Committee for review and recommendations to Council.

The EPPh Advisory Committee began to review the recommendation to include Travel Health under extended practice at the May 8th, 2017, meeting. It soon became apparent that additional information and discussion with pharmacists and other health providers practising or preparing for practice in travel health would be helpful in developing recommendations on whether travel health is better placed under Schedule 3 or as an extended practice. As well, there was the suggestion that certain limited aspects of travel health e.g., vaccination with Twinrix®, may be included under Schedule 3 with pharmacist education and the requirement for patient referral to a travel health practitioner when required. The decision was therefore made to form a small group of pharmacists with a special interest in travel and potentially include additional travel health practitioners to inform the EPPh Advisory Committee. Plans are currently underway to establish this group.

4. Recommendations regarding the use of a drug list using ATC codes in Schedule 3:

ATC codes (Anatomic Therapeutic Chemical Classification) is a system for the classification of drugs and was used as a method of listing specific drugs that could be prescribed by pharmacists in Schedule 3. It is the Committee's recommendation that pharmacists not be restricted to specific drugs under Schedule 3 but instead be permitted to prescribe within current nationally-adopted and recommended drug treatment guidelines for the condition.

Rationale:

The use of ATC codes in Schedule 3 has been shown to be problematic on several fronts. One example of the issues that have resulted from the use of ATC codes is that authorized pharmacists were only able to prescribe clindamycin and benzyl peroxide as separate drug products in the treatment of acne vulgaris rather than prescribing the preferred combination drug product, until such time that amendments could be made to Schedule 3 to include the ATC code for clindamycin combination drug products. This oversight in Schedule 3 was recognized soon after the legislation came into effect on January 1, 2014 and changes to include clindamycin combination products in Schedule 3 could not be completed until September 23, 2016. The long delay in correcting Schedule 3 for this oversight was the result of several factors including but not limited to, the use of ATC codes and a drug list and the additional need for member approval of amendments to the regulation.

In discussion, the Committee also recognized that the use of drug lists severely limits the pharmacist in their ability to prescribe according to changes in nationally-accepted and recommended drug treatment guidelines. For example, and again in the case of the self-limiting condition acne vulgaris, current first line treatment guidelines recommend the use of topical retinoids. As topical retinoids are not listed within Schedule 3, pharmacists are not able to prescribe treatment for their patients with acne vulgaris in line with recommended treatment guidelines and considerable time and effort will be required before pharmacists can do so. This will be a continuing issue with all conditions listed in Schedule 3 and the ability of pharmacists to respond to advances made to improve drug treatment guidelines for their patients, will be delayed.

In addition, it was determined through the environmental scan completed by the Committee that in the majority of the other provinces across the country, pharmacists do not prescribe to a drug list but rather, they prescribe to the current recommended drug treatment guidelines for the condition.

Conditions Considered but not Recommended

Condition	Notes
Allergic conjunctivitis	First and second line therapies are non-prescription. For persistent or more severe symptoms, a specific diagnostic procedure is required. This does not meet the definition of a self-limiting condition.
Candidal dermatitis (diaper dermatitis)	First line therapies are non-prescription.
Cough	First line therapies are non-prescription. Persistent or more severe cough requires additional investigations by the patient's primary care provider.
Dandruff	First line therapies are non-prescription.
Non-infectious diarrhea	First line therapies are non-prescription.
Dyspepsia	One-quarter of dyspepsia have an underlying organic cause that requires investigation. This does not meet the definition of a self-limiting condition.
Headache	First line therapies are non-prescription. The treatment of more severe headaches can mask an underlying condition (e.g. CNS infection, bleed, lesion). This did not meet the definition of a self-limiting condition.
Joint pain, mild	Drugs used to treat can be subject to abuse and first line therapies are non-prescription.
Muscle pain	Drugs used to treat can be subject to abuse.
Musculoskeletal strains/sprains	Drugs used to treat can be subject to abuse.
Nasal congestion	First and second line therapies are non-prescription.
Nausea	First line therapy is non-prescription. Additional treatment can mask an underlying condition. Vomiting in pregnancy is already included in Schedule 3.
Sleep disorders	Drugs used to treat can be subject to abuse and first line therapies are non-prescription.
Sore throat	The treatment of a sore throat requires a physical assessment and diagnosis by a physician or nurse practitioner. There can be serious patient health consequences should an incorrect decision to not treat be made and therefore, this condition did not meet the definition of self-limiting.
Mild upper respiratory conditions	This did not meet the definition of a self-limiting condition.
Xerophthalmia	First line therapies are non-prescription.

Rationale for Included Conditions

Contraception

Background:

Between 2013 and 2014, there were a total of 386,044 births in Canada and 82,869 induced abortions suggesting that many pregnancies in Canada may be unplanned ^{1,2}. Unplanned pregnancies have been associated with negative health and social outcomes for both mothers and children ³⁻⁵. A Canadian study found that 9% of sexually active women between the ages of 15 and 44 were not using any method of contraception and many were not familiar with the extent of contraceptive methods available ⁶.

Referral:

When obtaining patient's medical history it is identified that there are contraindications to hormonal contraceptives, they should be referred to an appropriate health care provider. Patients should also be referred if: pregnancy cannot be ruled out, blood pressure is elevated after multiple readings ($\geq 140/90$ mmHg), or concomitant use of clinically significant interacting medications (e.g. rifampin, griseofulvin).

Rationale:

Community pharmacist prescribing of hormonal contraceptives has been shown to be effective and feasible ⁷. In the U.S., many states, such as Oregon, California, Washington, Colorado, and New Jersey, have enacted legislation allowing pharmacists to prescribe self-administered hormonal birth control. It is generally universal that pharmacists must obtain a patient's relevant medical history, pregnancy status, and medication history, as well as perform blood pressure screening, before authorizing a prescription. This is achieved with a one page self-screening questionnaire, similar to those used for immunizations. The pharmacist can then follow an algorithm, such as the one used in Oregon (Appendix A) ⁸. It is important to note that the pharmacist cannot prescribe to a woman who is unable to provide evidence that she has visited a women's health provider within three years to prevent women from avoiding Pap tests.

Other than non-hormonal contraceptive methods (e.g. condom), a pharmacist would have the authorization to prescribe combined estrogen and progestin in oral, transdermal, and vaginal (e.g. NuvaRing) formulations as well as oral and injectable progestin only formulations.

References:

1. Statistics Canada. Births, estimates, by province and territory. Available from: www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/demo04a-eng.htm. Accessed April 21, 2017.
2. Canadian Institute for Health Information. Induced abortions reported in Canada in 2013. Available from: www.cihi.ca/en/quick-stats. Accessed April 21, 2017.
3. Altfeld S, Handler A, Burton D et al. Wantedness of pregnancy and prenatal health behaviors. *Women Health* 1997;26:29-43.

4. Wellings K, Wadsworth J, Johnson A et al. Teenage fertility and life chances. *Rev Reprod* 1999;4:184-90.
5. Botting B, Rosato M, Wood R. Teenage mothers and the health of their children. *Popul Trends* 1998;(93):19-28.
6. Fisher W, Boroditsky R, Morris B. The 2002 Canadian Contraception Study: part 1. *J Obstet Gynaecol Can* 2004;26:580-90.
7. Gardner JS, Miller L, Downing DF, et al. Pharmacist prescribing of hormonal contraceptives: results of the Direct Access study. *J Am Pharm Assoc* (2003). 2008 Mar-Apr;48(2):212-21; 5 p following 221. doi: 10.1331/JAPhA.2008.07138.
8. Oregon Board of Pharmacy. Oregon Pharmacists Prescribing of Contraceptive Therapy. <https://www.oregon.gov/pharmacy/Pages/ContraceptivePrescribing.aspx>. Accessed March 23, 2017

Urinary Tract Infection

Background:

Urinary tract infections (UTIs) remain one of the most common reasons patients seek medical attention in the community¹. Up to half of women presenting with symptomatic acute uncomplicated UTI may become symptom-free within seven days without using antibiotics. Although it is standard care to offer antimicrobial therapy, simple symptomatic treatment does not increase the risk of recurrent infections or pyelonephritis and could therefore be considered for treatment under self-limiting conditions².

Differential Assessment:

Pyelonephritis, vaginitis (commonly caused by vulvovaginal candidiasis), sexually transmitted infections, pelvic inflammatory disease, and nephrolithiasis are all relevant differential diagnoses.

Referral:

The scope of this condition is uncomplicated, recurrent cystitis in non-pregnant women. Therefore, those patients presenting with the following conditions should be referred to an appropriate health care provider: UTI treatment less than one month ago, anatomic abnormality (cystocele, diverticulum, fistula), catheterized, vesicoureteric reflux, neurologic disease resulting in voiding dysfunction, obstruction (bladder outlet obstruction, ureteral stricture, ureteropelvic junction obstruction, urolithiasis), and immunocompromised³. These preceding conditions place patients into the complicated treatment category.

Rationale:

“The probability of cystitis is greater than 50 percent in women with any symptom of urinary tract infection [dysuria, frequency, urgency, suprapubic pain, and/or hematuria] and greater than 90 percent in women who have dysuria and frequency without vaginal discharge or irritation³. Thus, urinalysis or culture usually add little to the diagnostic armamentarium in women with typical cystitis symptoms and are often not indicated in such cases.”⁵. Furthermore, “results of the dipstick test provide little useful information when the history is strongly suggestive of urinary tract infection, since even negative results for both tests do not reliably rule out the infection in such cases”⁵.

A trial evaluating patient self-diagnosis reported as being accurate in 84-94% of cases ⁶. Additionally, patient satisfaction was very high in this trial; patients felt comfortable with self-diagnosis which allowed for earlier treatment, shortened the course of symptoms, and allowed earlier resumption of daily activities ⁶.

Therefore, as it can be reliably self-diagnosed by the patient, laboratory tests are not required for diagnosis, and treatment will not mask the underlying conditions, the Committee believed that cystitis is an appropriate condition to be listed under self-limiting conditions.

Treatment options are suggested to be limited to sulfamethoxazole plus trimethoprim 800/160mg orally twice per day for three days in those with a creatinine clearance >30ml/min, trimethoprim monotherapy 200mg orally once daily for three days, nitrofurantoin 100mg orally twice per day (macrocrystal formulation) or 50-100mg orally four times daily for five days in those with a creatinine clearance >30ml/min, or fosfomycin provided as a single, 3g oral dose ³.

References:

1. Touchie C. (2013). Report of the Incidence and Prevalence of Diseases and Other Health Related Issues in Canada: A Study for the MCC Blueprint Project. Retrieved from Medical Council of Canada website: <http://mcc.ca/wp-content/uploads/Touchie-Incidence-Prevalence-Report.pdf>
2. Bleidorn J, Hummers-Pradier E, Schmiemann G et al. Recurrent urinary tract infections and complications after symptomatic versus antibiotic treatment: follow-up of a randomised controlled trial. *Ger Med Sci* 2016;14:Doc01.
3. RxFiles Newsletter. Antibiotics & Common Infections ABX-2: Uncomplicated Cystitis & Skin Stewardship, Effectiveness, Safety & Clinical Pearls. April 2017
4. Bent S, Nallamothu BK, Simel DL, et al. Does this woman have an acute uncomplicated urinary tract infection? *JAMA*. 2002;287(20):2701
5. Hooton T, Gupta K. Acute uncomplicated cystitis and pyelonephritis in women. <http://www.uptodate.com>. Updated March 2017.
6. Gupta K, Hooton TM, Roberts PL, Stamm WE. Patient-Initiated Treatment of Uncomplicated Recurrent Urinary Tract Infections in Young Women. *Ann Intern Med* 2001; 135:9-16

Gastroesophageal Reflux Disease

Background:

Gastroesophageal reflux disease (GERD) is a common complaint classically defined as heart burn and acid regurgitation without evidence of structural disease to explain the symptoms ¹. Patients frequently self-manage without seeking medical attention ².

Differential Assessment:

Symptoms overlap considerably with dyspepsia making it difficult to differentiate between the two ³. Alternative diagnoses that need to be considered are: cardiovascular disease, peptic ulcer disease, functional dyspepsia, biliary disease, and medications as a cause ⁴.

Referral:

Patients must be referred immediately when alarm features are identified (VBAD; vomiting, bleeding, abdominal mass/unexplained weight loss, dysphagia/odynophagia) or with features suggestive of a cardiac nature. Additionally, patients should be referred if unexplained cough/dyspnea/hoarseness is identified, age <18 or >50 years (if new onset of undiagnosed symptoms), severe symptoms affecting sleep or daily activities, and in pregnancy.

Rationale:

H2 receptor antagonists (H2RA) became available without a prescription early 2007. Since then, pharmacists have been appropriately recommending their use following assessment. Proton pump inhibitors are more effective than H2RAs in the treatment of GERD with one in six additional people achieving complete symptom control⁵. In 2014, then in 2016, omeprazole then esomeprazole were deemed safe enough to be listed as a NAPRA Schedule II medication meaning it is available without a prescription but requires a pharmacist intervention.

The addition of GERD will formalize what pharmacists are already doing in practice and expand the medication options to prescribe from. A proposed treatment algorithm can be seen as attached as Appendix B⁴.

References:

1. Talley NJ, Ford AC. Functional dyspepsia. *N Engl J Med* 2015;373:1853-63.
2. Kahrilas PJ, Shaheen NJ, Vaezi MF et al. American Gastroenterological Association Institute technical review on the management of gastroesophageal reflux disease. *Gastroenterology* 2008;135:1392-413.
3. Pham CQD. Dyspepsia and GERD. <http://www.e-therapeutics.ca>. Updated April 2016
4. medSask. Gastroesophageal Reflux Disease (GERD) - Guidelines for Prescribing H2RAs and PPIs. <https://medsask.usask.ca/professional/guidelines/gerd.php>. Accessed May 23, 2017.
5. Talley NJ, Moore MG, Sprogis A, Katelaris P. Randomised controlled trial of pantoprazole versus ranitidine for the treatment of uninvestigated heartburn in primary care. *Med J Aust*. 2002 Oct 21;177(8):423-7.

Corns, Calluses, and Warts (Excluding Facial and Genital)**Background:**

The pathophysiology is different between corns, calluses, and warts with warts being caused primarily by human papilloma viruses which develop from excessive friction or pressure leading to keratinization over activity^{1,2}. While generally benign, they can be quite painful to some and may present a cosmetic concern or even have a social stigma.

Differential Assessment:

With irregular growth or ulceration, one must consider squamous cell carcinoma³. Acrochordons (skin tags), black heel, lichen planus/nitidus, and amelanotic melanoma should also be considered³.

Referrals:

Those who are immunocompromised or with significant neuropathy should be referred. For those in whom self-treatment cannot be monitored (e.g. elderly patient that cannot physically see treatment area) or with structural abnormalities complicating treatment can also be considered for referral.

Rationale:

Although the vast majority of treatment options are already available over-the-counter, salicylic acid 40% is only available as a pad. On flexural areas, pads do not stick well and it may be preferable to use a compounded ointment formulation. Self or practitioner applied 0.5% podophyllin could also be considered as a treatment option within this condition but not in combination with other therapies, such as cantharidin ^{3,4}. The addition of this condition again formalizes standard practice and allows the use of additional therapies.

References:

1. Mallin A. Corns, Calluses, Bunions and Ingrown Toenails. <http://www.e-therapeutics.ca>. Updated April 2016.
2. Mallin A. Plantar Warts. <http://www.e-therapeutics.ca>. Updated May 2016.
3. Goldstein B, Goldstein A, Morris-Jones R. Cutaneous warts. <http://www.uptodate.com>. Updated November 2015.
4. Coutinho B. Molluscum Contagiosum. <https://www.essentialevidenceplus.com>. Updated May 2017.

Dysmenorrhea**Background:**

Primary dysmenorrhea, or painful periods, are attributed to prostaglandin mediated uterine contractions without underlying pathology ¹. Approximately half of all women experience primary dysmenorrhea at some point in their lives with the peak incidence between 20 and 24 years of age. It is reported as being the most common cause of missed school or workdays in young women ².

Differential Assessment:

Pharmacists must differentiate between primary and secondary dysmenorrhea and should rule out pregnancy. There are a number of other conditions which can cause similar pain: abnormal uterine structure, adenomyosis, cystitis, ectopic pregnancy or miscarriage, endometriosis, uterine fibroids, inflammatory bowel disease, irritable bowel syndrome, and pelvic inflammatory disease.

Referral:

Those with suspected secondary dysmenorrhea should be referred to target and treat the specific underlying cause. "Cues that additional patient evaluation is required include onset of pain more than two years postmenarche, symptoms that occur outside the first three days of menses, changes in the severity or pattern of the pain or in the characteristics of the menstrual fluid (e.g., degree of flow, odour, colour, flow pattern)," ² persistent bleeding between periods, patient reports palpable abdominal

or pelvic lump, non-midline pain or unilateral pain, or those with contraindications to first line treatment.

Rationale:

Nonsteroidal anti-inflammatory drugs (NSAIDs) are one of the first line options for pharmaceutical treatment of dysmenorrhea ¹⁻³. ASA, naproxen, and ibuprofen are all available over-the-counter, although ASA may not be as effective ¹. Mefenamic acid, a prescription NSAID, may have slightly greater efficacy compared to other NSAIDs possibly due to a more complete block of activity against prostaglandins ³. A treatment algorithm has been developed for pharmacist prescribing (Appendix C) ¹. For those who also desire contraception, oral contraceptives are considered a first line option (see “Contraception” for additional rationale).

References:

1. medSask. Dysmenorrhea - Guidelines for Prescribing NSAIDs. <https://medsask.usask.ca/professional/guidelines/dysmenorrhea.php>. Accessed May 23, 2017.
2. Brown T. Dysmenorrhea. <http://www.e-therapeutics.ca>. Updated April 2016.
3. Smith R, Kaunitz A. Treatment of primary dysmenorrhea in adult women. <http://www.uptodate.com>. Updated June 2016.

Emergency Contraception

Background:

The use of emergency contraception, also referred to as the “morning after pill”, is intended following an isolated act of intercourse as a means to avoid unplanned pregnancy ¹. Ideally, emergency contraception should be used as soon as possible with the greatest efficacy within the first 72 hours ². It is not as effective as contraceptives used on a regular basis and, therefore, should prompt a discussion on effective contraceptive methods ¹.

Referral:

If a sexually transmitted infection is suspected, patient should be referred to an appropriate health care provider following the administration of emergency contraception. Refer if known or suspected pregnancy or undiagnosed vaginal bleeding. Discuss efficacy and possible referral if BMI ≥ 30 kg/m².

Pharmacist Prescribing Rationale:

With the efficacy of treatment declining over time, access to emergency contraception in a timely fashion is essential. It has already been recognized that pharmacies are highly accessible to the public and have already been prescribing levonorgestrel as an emergency contraception method. By including emergency contraception under Schedule 3 of the Regulation, pharmacists may then also prescribe the Yuzpe regimen and ulipristal acetate. Ulipristal acetate is a newer agent which extends the time to use to five days and may be slightly more effective than levonorgestrel ^{3,4}. Both ulipristal and levonorgestrel is more effective than the Yuzpe regimen ^{3,4}.

References:

1. Whelan A. Contraception. <http://www.e-therapeutics.ca>. Updated April 2016
2. Bastianelli C, Farris M, Benagiano G. Emergency contraception: a review. *Eur J Contracept Reprod Health Care* 2008;13:9-16.
3. Lexicomp Online ®, Levonorgestrel (Systemic) Lexi-Drugs. Hudson , Ohio: Lexi-Comp, Inc.; May 23, 2017
4. Cheng L, Che Y, Gulmezoglu AM. Interventions for emergency contraception. *Cochrane Database Syst Rev* 2012;8:CD001324

Impetigo

Background:

Impetigo is a highly contagious bacterial skin infection common in children, but can affect patients of any age ¹. It presents as two distinct types: bullous and non-bullous. The non-bullous type is the most common and frequently presents as papules that progress to small blisters surrounded by erythema. These papules dry over two to three days leaving a characteristic honey-coloured crust. Lesions often present on the central face or extremities and is caused by *Staphylococcus aureus*.

Differential Assessment:

Contact dermatitis, ecthyma, tinea corporis, herpes zoster/simplex, scabies, Stevens-Johnson syndrome, and scalded skin syndrome or burns are included in the differential ^{1,2}.

Referral:

Patients should be referred to their primary care provider if no response is seen within 48 hours, worsens or spreads at any time, or recurs within three months (to rule out methicillin-resistant *S. aureus*).

Topical therapy is not appropriate for patients with multiple, extensive, or recurrent lesions, fever/constitutional symptoms/lymphadenopathy, immunocompromised, or those with valvular heart disease. Oral antibiotics are the treatment of choice for these patients. Oral therapy may also be indicated as a means of decreasing transmission during outbreaks. Therefore, these patients should also be referred to their primary care provider.

Rationale:

Most importantly, treatment with antibiotics decreases spread of disease and significantly shortens the duration of the contagious period. It also provides quicker resolution of lesions by one to two days ¹⁻³. Treatments are also safe and cost-effective. Topical antibiotics, such as mupirocin or fusidic acid 2% applied three to four times per day for five to seven days, are as effective as oral antibiotics for limited and localized impetigo ⁴. As this is diagnosed on the basis of clinical manifestations, is highly contagious, and treatment is safe and effective, the Committee recommends that this condition is appropriate to be included in self-limiting conditions.

References:

1. medSask. Superficial Bacterial Skin Infections - Guidelines for Prescribing Topical Antibiotics for impetigo and folliculitis. <https://medsask.usask.ca/professional/guidelines/superficial-bacterial-skin-infections.php>. Accessed May 23, 2017.
2. Miller P. Bacterial Skin Infections: Impetigo, Furuncles and Carbuncles. <http://www.e-therapeutics.ca>. Updated October 2016.
3. Baddour L. Impetigo. <http://www.uptodate.com>. Updated September 2016.
4. RxFiles Newsletter. Antibiotics & Common Infections ABX-2: Uncomplicated Cystitis & Skin Stewardship, Effectiveness, Safety & Clinical Pearls. April 2017

Folliculitis

Background:

Hair follicles can become infected resulting in red, itchy papules/pustules found commonly on the neck, groin, or armpits ¹. As the infection extends into deeper layers of the skin it tends to cause more pain and is then referred to as furuncles, colloquially known as boils.

Differential Assessment:

Evaluation is based on patient history and symptoms. Conditions that present with similar symptoms include: pseudofolliculitis barbae, irritant/contact folliculitis, acne vulgaris, cysts, candidiasis, hidradenitis suppurativa, Fox-Fordyce disease, or necrotizing fasciitis ^{1,2}.

Referral:

Patients are better suited for treatment from their primary care provider if: they are immunocompromised, the affected area is larger than two or three small patches, presents with constitutional symptoms, frequent recurrences, if MRSA is suspected based on patient risk factors, or if lesions worsen at any time during treatment or if no improvement is seen within 48 hours ¹.

Rationale:

Folliculitis is a relatively common self-limiting condition primarily treated with non-pharmacological options. However, if it persists for a week, this is an indication for topical antibiotics. Both mupirocin and fusidic acid 2% are indicated and are suggested to be applied to the affected area three times a day for seven days ^{1,3}. This condition and associated treatment options meet the pre-defined self-limiting condition criteria and therefore, the Committee recommends to include this under Schedule 3.

References:

1. medSask. Superficial Bacterial Skin Infections - Guidelines for Prescribing Topical Antibiotics for impetigo and folliculitis. <https://medsask.usask.ca/professional/guidelines/superficial-bacterial-skin-infections.php>. Accessed May 23, 2017.
2. Jackson J. Infectious folliculitis. <http://www.uptodate.com>. Updated October 2015.
3. Ely J. Folliculitis. <http://www.essentialevidenceplus.com>. Updated August 2015.

Herpes Labialis

Background:

Herpes labialis, occurring due to herpes simplex virus-1 or herpes simplex virus-2, may lead to multiple recurrences that are characterized by a prodromal phase, then an eruption of a lesion on the vermilion border of the lips¹. The recurrence often occurs in response to a trigger such as: emotional stress, sunlight, trauma, hormonal fluctuations, fever or upper respiratory tract infections^{1,2}. Generally, the recurrence takes between seven to ten days to heal completely¹.

Differential Assessment:

Patient assessment of symptoms, presentation timeline as well as location helps differentiate herpes labialis from other oral conditions such as recurrent aphthous ulcers and oral candidiasis. Herpes labialis is considered a self-care condition in immunocompetent individuals¹.

Referrals:

Currently, it is recommended that patients who are immunocompromised should be referred to a physician for further evaluation¹. As well, patients with frequent episodes (greater than six per year), systemic or ocular symptoms, or if the lesions appears infected should also be referred^{1,3}.

Rationale:

The majority of current non-prescription options to treat this condition are used for symptom management. The exception is the non-prescription topical antiviral of docosonal which may reduce the timeframe for lesion healing by one to three days¹.

Prescription oral antivirals used as intermittent episodic therapy have been found to be effective when started early in the symptom presentation¹. Furthermore, these options have a similar adverse effect profile as placebo therapy⁴. Therefore, the ease of access to a pharmacist when the patient is initially experiencing symptoms, the benefit of treatment by oral antivirals and the relative safety of short courses of the treatment all provide a justification as to why this condition is ideal for pharmacists to have an active role in prescribing and managing the patient's recurrent cold sore.

Pharmacist prescribing oral antivirals would be for healthy children (two years old or older) and adults³. If a patient had reduced kidney function, a referral would be recommended if the pharmacist did not have access to the patients' lab values required to calculate creatinine clearance.

References:

1. Conklin J. Chapter 90: Cold Sores. In: Repchinsky C. (Eds.) (2016) Compendium of Therapeutics for Minor Ailments, 2nd edition (CTMA 2). Ottawa, ON: Canadian Pharmacists Association. p. 1204-1211.
2. Goldstein BG and AO Goldstein. Oral lesions. www.uptodate.com Updated January 2017. Accessed May 11, 2017.
3. medSask. Cold Sore - Guidelines for Prescribing Oral Antivirals. <https://medsask.usask.ca/professional/guidelines/cold-sore.php>. Accessed May 9, 2017.

4. Evans GA. Chapter 112: Herpesvirus Infections. In: Jovaisas B. (Eds.) (2014) Compendium of Therapeutic Choices, 7th Edition (CTC 7). Ottawa, ON: Canadian Pharmacists Association. p. 1344-1358.
5. Klein RS. Clinical manifestations and diagnosis of herpes simplex virus type 1 infection. www.uptodate.com Updated Nov. 9, 2016.
6. Klein RS. Treatment of herpes simplex virus type 1 infection in immunocompetent patients. www.uptodate.com Updated Sept. 25, 2015.

Tinea Cruris

Background:

Tinea Cruris is a dermatophyte infection that often happens in conjunction with a tinea pedis infection ¹. It occurs in middle to upper thigh area and the groin ². Symptoms appear bilaterally with erythematous lesions that often have a fine scale ^{1,2}. Pruritus is significant and small vesicles may also be present ². Tinea cruris is considered a self-care condition in Canada and the U.S.

Differential Assessment:

The clinical determination of a tinea cruris infection from a pharmacist perspective is often based on lesion appearance, location and associated symptoms of itch. As well, a thorough patient assessment should be completed to determine predisposing factors to help confirm differential diagnosis.

A physician may confirm a tinea cruris infection by performing a potassium hydroxide examination, and fungal cultures ³.

Referrals:

Currently, it is recommended to refer patients who are immunocompromised (due to medications or a medical conditions), infection occurring due to a cause that is not determined, or patient is experiencing debilitating, severe or inflammatory symptoms ¹. Patients that do not respond within the appropriate timeframe to topical treatment or are unable to tolerate topical treatment should also be referred ¹.

If pharmacists prescribe for a tinea cruris infection, the aforementioned referral categories would be maintained.

Rationale:

The treatment options for an uncomplicated tinea cruris infection include non-prescription and prescription options. The prescription options of ciclopirox and terbinafine creams are included within the scope of a pharmacist eligible to prescribe for tinea pedis. Considering that tinea pedis and tinea cruris often occur at the same time in patients, pharmacist prescribing for this condition would allow for the patient to receive a complete treatment plan. Furthermore, the prescription treatment option of terbinafine cream is available over-the-counter in the U.S. ⁴.

References:

1. Miller PF. Chapter 65: Fungal Skin Infections. In: Repchinsky C. (Eds.) (2016) Compendium of Therapeutics for Minor Ailments, 2nd edition (CTMA 2). Ottawa, ON: Canadian Pharmacists Association.
2. Newton GD. Chapter 41: Fungal Skin Infections. In: Krinsky DL, et al (2015). Handbook of Nonprescription Drugs: An Interactive Approach to Self-Care, 18th Edition. Washington, DC: American Pharmacists Association.
3. Goldstein AO and BG Goldstein. Dermatophyte (tinea) infections. www.uptodate.com Updated May 2017. Accessed May 11, 2017.
4. FDA. Terbinafine topical cream. <https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm?event=overview.process&applno=077511> Accessed May 11, 2017.

Tinea Corporis

Background:

A dermatophyte infection that generally occurs on exposed areas of skin ¹. Most commonly, the lesions are oval or circular with a clear centre and a red, scaly border. This is considered to be a condition that patients can self-diagnose and treat ¹.

Differential Assessment:

A tinea corporis infection is differentiated from other skin lesions such as psoriasis, bacterial infection, seborrhea dermatitis, contact or atopic dermatitis through an assessment of the appearance of the lesion ^{1,2}.

A physician may confirm a tinea corporis infection by performing a potassium hydroxide examination and fungal cultures.³

Referrals:

The recommendation criteria for referring is similar to tinea cruris as any patients with decreased immune function should be referred ¹. As well, if the cause of the tinea corporis is unknown or if the infection is widespread or severe, a referral is necessary. Systemic symptoms also require the patient be referred for further evaluation ¹. Lastly, if a patient does not have an adequate response to the treatment within a reasonable timeframe, or they cannot tolerate the treatment, they should also be referred ¹.

These criteria would be maintained if pharmacists can prescribe for a tinea corporis.

Rationale:

Options for the treatment of an uncomplicated tinea corporis infection include non-prescription and prescription topical options. The prescription options of ciclopirox and terbinafine creams are included within the scope of a pharmacist eligible to prescribe for other tinea infections (pedis). Furthermore, the prescription treatment option of terbinafine cream is available over the counter in the U.S. ⁴.

References:

1. Miller PF. Chapter 65: Fungal Skin Infections. In: Repchinsky C. (Eds.) (2016) Compendium of Therapeutics for Minor Ailments, 2nd edition (CTMA 2). Ottawa, ON: Canadian Pharmacists Association.
2. Newton GD. Chapter 41: Fungal Skin Infections. In: Krinsky DL, et al (2015). Handbook of Nonprescription Drugs: An Interactive Approach to Self-Care, 18th Edition. Washington, DC: American Pharmacists Association.
3. Goldstein AO and BG Goldstein. Dermatophyte (tinea) infections. www.uptodate.com Updated May 2017. Accessed May 11, 2017.
4. FDA. Terbinafine topical cream. <https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm?event=overview.process&applno=077511> Accessed May 11, 2017.

Recurrent Vaginal Candidiasis

Background:

The terminology of recurrent vaginal candidiasis is meant to be defined as a vaginal candidiasis infection occurring in a patient that had been previously diagnosed by a physician and the patient is experiencing similar symptoms to the previously treated and resolved infection. An uncomplicated infection presents with the symptoms of itching, burning and discharge similar to “cottage cheese” ¹.

Differential Assessment:

A thorough gathering of information regarding the patient’s symptoms is required in the assessment to confirm symptoms are consistent with a vaginal candidiasis infection and to rule out other vaginal conditions such as bacterial vaginosis, trichomoniasis or atrophy ¹.

Referrals:

Due to the potential of other conditions presenting with similar symptoms, the current recommendations for when a patient should be referred would be maintained if pharmacists can prescribe for this condition. Referral for further evaluation is recommended if: the patient is prepubescent, or has never had a vaginal candidiasis prior, or has an illness that may contribute to the infection or is immunosuppressed, or is pregnant or at risk for experiencing a sexually transmitted infection ¹. Additionally, a patient should be referred if their last vaginal candidiasis infection was within two months ¹.

Rationale:

Overall, the options for treatment of a vaginal candidiasis infection would remain similar to what is currently available without a prescription (oral fluconazole, topical clotrimazole or miconazole). Pharmacist’s assessment of the condition is ideal due to easy accessibility and the lack of patients being able to correctly self-assess this condition. One study found that only 35% of females who had previously had this infection, could correctly identify a case example with the classic symptoms of vaginal candidiasis ².

The potential additional option is vaginal terconazole. This is a seven day treatment which may or may not be preferable for patients but allows for greater therapeutic options to the patient and pharmacist.

References:

1. Pollock LL. Chapter 84: Vaginal Symptoms, Hygiene and Infections. In: Repchinsky C. (Eds.) (2016) Compendium of Therapeutics for Minor Ailments, 2nd edition (CTMA 2). Ottawa, ON: Canadian Pharmacists Association.
2. Lodise NM. Chapter 8: Vaginal and Vulvovaginal Disorders. In: Krinsky DL, et al (2015). Handbook of Nonprescription Drugs: An Interactive Approach to Self-Care, 18th Edition. Washington, DC: American Pharmacists Association.
3. Sobel JD. Candida Vulvovaginitis www.uptodate.com Updated October 2016. Accessed May 11, 2017.

Pinworms

Background:

Enterobius vermicularis is a relatively minor parasite that tends to spread and infect families ¹. The most common symptoms include itching in the anal area, particularly at night, so sleep may be affected ¹. Some individuals will not experience symptoms ².

Differential Assessment:

Diagnosis of pinworms is recommended to be confirmed by a physician ¹. Prior to treatment, visualization of a pinworm or nighttime perianal itching should be verified ³. Another option to establish if pinworms are present is to complete the scotch tape test ¹.

Referrals:

As mentioned previously, confirmation of a pinworm infection by a physician is recommended.

Rationale:

Due to the ease of becoming infected with pinworms when a close contact has an active pinworm infection, the treatment is recommended for all close contacts - regardless if they are experiencing symptoms. With pharmacists having the ability to prescribe for this condition, this allows the choice between two agents: pyrantel pamoate (non-prescription) and mebendazole (prescription). Mebendazole administration may be easier as it is a standard dose for everyone that is not dependent on weight ¹. If pharmacists can prescribe for pinworms, then allowing the option of mebendazole treatment provides the opportunity to evaluate two options to ensure that the patient is receiving the most appropriate treatment.

References:

1. Chan J. Chapter 39: Pinworms. In: Repchinsky C. (Eds.) (2016) Compendium of Therapeutics for Minor Ailments, 2nd edition (CTMA 2). Ottawa, ON: Canadian Pharmacists Association.
2. Centers for Disease Control and Prevention. Parasites - Enterobiasis (also known as Pinworm Infection). https://www.cdc.gov/parasites/pinworm/gen_info/faqs.html Accessed May 12, 2017.
3. Goad JA and E Mirzaian. Chapter 18: Pinworms. In: Krinsky DL, et al (2015). Handbook of Nonprescription Drugs: An Interactive Approach to Self-Care, 18th Edition. Washington, DC: American Pharmacists Association.

Part II

Additional Considerations

In compiling this discussion document, there were a number of conditions identified that fell outside of the review of the Committee but, warrant further consideration and discussion. These conditions do not fit within the criteria for treatment of a self-limiting condition. Evidence exists however, to support that pharmacist prescribing for these conditions, improves patient care and safety.

Pharmacist prescribing for these additional conditions would require modification to the regulatory framework from that of self-limiting conditions to include the requirement for the pharmacist prescribing to be done in collaboration with the physician, nurse practitioner or other designated health professional that has assessed the patient and diagnosed the condition. Some conditions listed in this category may include conditions that have been previously treated and have recurred and/or they may be conditions for which the drug treatment requires appropriate laboratory monitoring.

The Saskatchewan College of Pharmacy Professionals will be taking a similar two-tiered approach to pharmacist prescribing; those conditions suitable for self-limiting conditions, and those that require a previous assessment/diagnosis by an appropriate health care provider. This may represent a viable option for Manitoba for greater access to timely patient care in the community that would improve patient health outcomes and safety.

Conditions for which pharmacist prescribing could be considered in collaboration with a physician, nurse practitioner or other designated health professional that has assessed the patient and diagnosed the condition include the following.

Hypertension

A recent cost-effectiveness study in the CPJ outlined the potential benefits that could be realized if pharmacists were to practice to their full scope in the treatment of hypertension ¹. Taking into account the cost of the intervention and the expected direct cost savings, the authors estimated a cost savings to the health care system of over \$6000 per patient. The cost advantage comes primarily from a reduction of two cardiovascular events for every ten patients treated.

The study used the results from a previous clinical trial of pharmacist intervention which found an 18 mmHg reduction in systolic blood pressure ². The intervention consisted of pharmacists providing assessment and counseling to patients as well as initiating new antihypertensive or titrating the dose of existing medications. Management of hypertension should be broadly looked at as managing cardiovascular disease. As such, pharmacists also prescribed low dose ASA and statins to participants within that study.

Herpes Zoster

Although not publically funded (except in Ontario), the herpes zoster vaccine (Zostavax) is recommended as a single booster for all adults 60 years of age or older by the National Advisory Committee on Immunization ³. After consultation with a health care professional, the patient could make an informed decision on the value of the immunization and the pharmacist could prescribe and inject.

Allergic conjunctivitis

This condition is chronic and often follows a fluctuating pattern. Following diagnosis and initial treatment from an appropriate health care provider, follow up prescriptions could be provided by a pharmacist. Suggested products listed under this category would be: ketotifen, lodoxamide, nedocromil, and olapatadine drops.

Migraine

Initial assessment of migraine headache includes a neurological exam which is to be performed by the patient's primary care provider ⁴. Following this, continuation of management could be performed by the pharmacist. Pharmacists already monitor for triptan overuse and side effects and under this category, it is suggested that they could prescribe triptans.

Erectile dysfunction

Ruling out and/or treating other causes of erectile dysfunction by the patient's primary care provider are the first steps in appropriate management of this condition ⁵. In many cases, non-pharmacologic treatment modalities play a large role; but if required, selective phosphodiesterase-5 inhibitors (PDE5-I; sildenafil, tadalafil, and vardenafil) could be prescribed by the pharmacist. The pharmacist can also have a role in identifying drug causes of sexual dysfunction to ensure a PDE5-I is required.

Onychomycosis

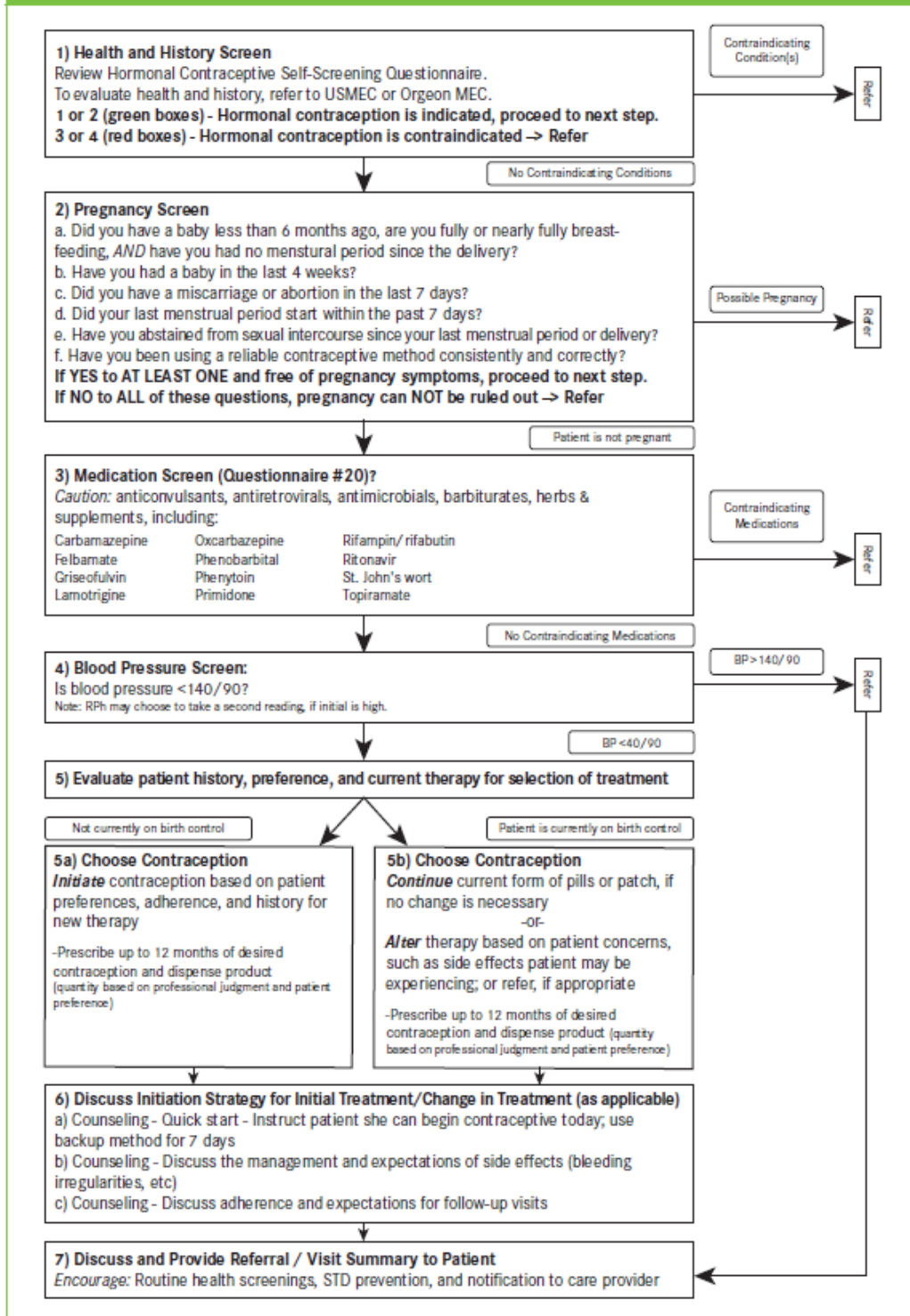
The treatment of onychomycosis (fungal nail infection) can be difficult. Topical treatment is recommended for mild, distal infections and is preferred over orals as they do not have the same potential for serious side effects ⁶. Treatment takes at least 21 weeks and up to 48 weeks depending on location of infection and reinfection is common ⁷. It would be recommended that pharmacists have prescriptive authority for topical products following an initial diagnosis.

References

- 1) Marra C, Johnston K, Santschi V, Tsuyuki RT. Cost effectiveness of pharmacist care for managing hypertension in Canada. *Can Pharm J (Ott)*. 2017 Mar 21;150(3):184-197. doi: 10.1177/1715163517701109. eCollection 2017 May-Jun.
- 2) Tsuyuki RT, Houle SK, Charrois TL, et al. Randomized Trial of the Effect of Pharmacist Prescribing on Improving Blood Pressure in the Community: The Alberta Clinical Trial in Optimizing Hypertension (RxACTION). *Circulation*. 2015 Jul 14; 132(2):93-100.
- 3) Baclic O, Kumar D, Mah A. An Advisory Committee Statement (ACS) National Advisory Committee on Immunization (NACI): Update on the Use of Herpes Zoster Vaccine. Ottawa. Available at: <https://www.canada.ca/en/public-health/services/publications/healthy-living/update-use-herpes-zoster-vaccine.html#usage>. Accessed May 28, 2017.
- 4) Cutrer FM, Bajwa ZH. Pathophysiology, clinical manifestations, and diagnosis of migraine in adults. <http://www.uptodate.com>. Updated March 2017.
- 5) Smiley T. Male Sexual Dysfunction. <http://www.e-therapeutics.ca>. Updated March 2016
- 6) Lee M, Jensen B, Regier L. Antifungals: Treatment Chart. RxFiles drug comparison charts. 11th ed. Saskatoon, SK: Saskatoon Health Region; 2017. p. 78.
- 7) Miller P. Fungal Nail Infections (Onychomycosis). . <http://www.e-therapeutics.ca>. Updated April 2016

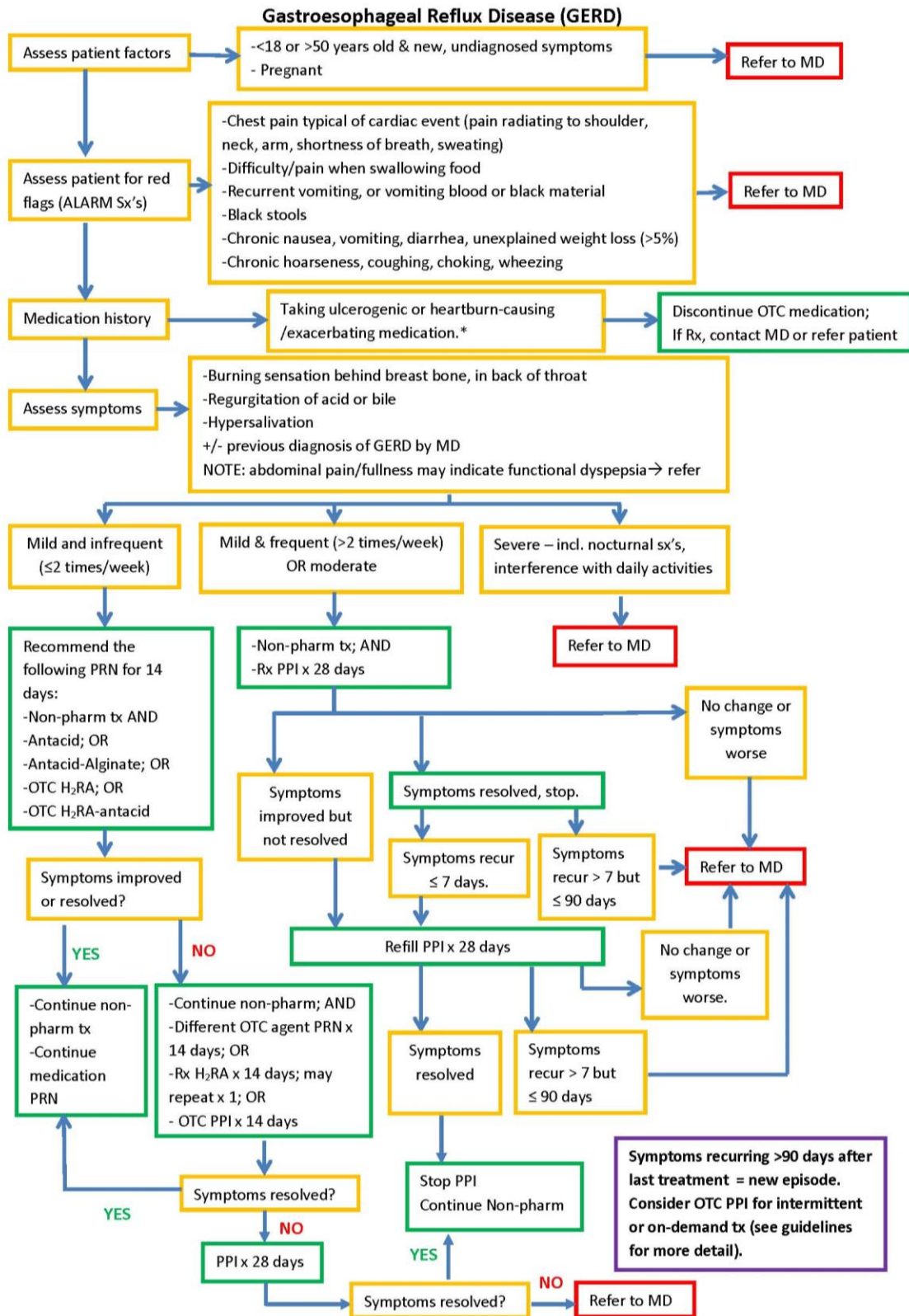
Appendix A

FIGURE. STANDARD PROCEDURES ALGORITHM FOR OREGON PHARMACIST PRESCRIBING OF CONTRACEPTIVES



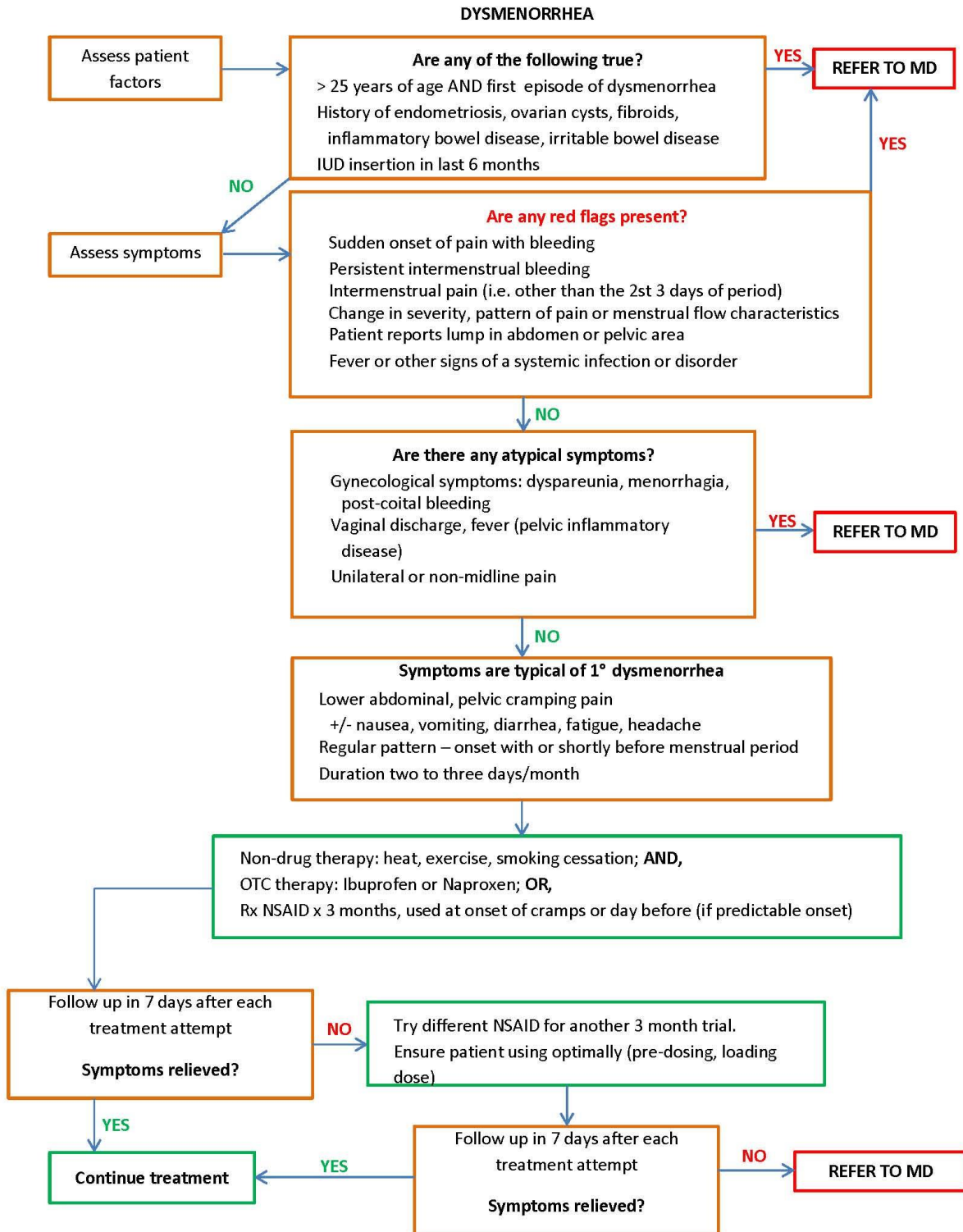
BP = blood pressure; STD = sexually transmitted disease.

Appendix B



* α -adrenergic agonists, anticholinergics, β -agonists, benzodiazepines (diazepam), bisphosphonates (alendronate), calcium channel blockers (amlodipine, felodipine, nifedipine), ethanol, iron, nicotine, NSAIDs (incl. ASA & Cox-2 inhibitors), potassium, progesterone, quinidine, tetracyclines, theophylline

Appendix C



Discussion Document on Streamlining the Regulation Amendment Process



Contents

- Issue 1
- Current Status 1
- Background 1
- Quick Facts about the Proposal to Streamline the Regulation Amendment Process 2
- Action 2



College of Pharmacists of Manitoba

200 Tache Avenue, Winnipeg, Manitoba R2H 1A7

Phone (204) 233-1411 | Fax: (204) 237-3468

E-mail: info@cphm.ca | Website: www.cphm.ca

Issue

Government has proposed a revised process to streamline the regulation amendment procedure which will result in a change to *The Pharmaceutical Act*. Details will be announced at the upcoming Special General Meeting (SGM) on June 19, 2017.

Current Status

The College is engaged in a process of consultation with members to determine if members are supportive of a legislative change to *The Pharmaceutical Act* so that Regulation amendments brought forward by Council are forwarded directly to government for consideration, following member, public and stakeholder consultation.

Background

At our recent Annual General Meeting (AGM), members Carey Lai and Barrett Procyshyn spearheaded a motion asking Council to review and seek amendments to the Pharmaceutical Regulation (Regulation). The goal of this motion is to expand pharmacist prescribing authority with respect to self-limiting conditions and travel health to better align with pharmacy practice across Canada. At the AGM, Vice-President Kevin Hamilton described the work that has happened since October 2015 by Council's Ad-hoc Committee on Self-Limiting Conditions to identify additional self-limiting conditions that may also be added to the Regulation. Please see the [Discussion Document on Pharmacist Prescribing](#) for details.

Council heard the memberships' message and shares its views regarding the need to amend the Regulation to add additional self-limiting conditions for which authorized pharmacists can prescribe medication to improve timely access to needed patient care. Executive Committee members brought this important issue forward as a priority during a meeting with government.

At that meeting, the Executive Committee was reminded of the fact that the College's regulation amendment process is out of alignment with almost every health profession in this province in that members must vote to approve regulations. This added step makes our profession slow to implement changes needed to improve patient care and safety, in comparison to the other health professions. Government presented the College with the opportunity to streamline our regulation amendment process through a legislative proposal to amend *The Pharmaceutical Act* so that Regulation amendments brought forward by Council are sent directly to government for consideration, following a robust member and stakeholder consultation process. This change will bring our Regulation amendment process for pharmacy practice in line with the vast majority of healthcare professions. The proposed change will allow the College to respond in a far timelier manner to make improvements that will enhance patient care and safety.

*College of Pharmacists of Manitoba Mission:
To protect the health and well being of the public by ensuring and
promoting safe, patient-centred and progressive pharmacy practice.*

Member of the National Association of Pharmacy Regulatory Authorities

Government then requested the College engage with membership to gauge its support for this amendment. The Executive Committee spent time considering this request and decided that the best way to measure member support for a legislative change was an electronic survey sent to all voting members. On Tuesday, May 9, 2017 the survey was sent out and was closed on Friday, May 12, 2017. The survey found that 84 per cent of participating members were in support of a legislative change that will streamline the College's regulation amendment process.

These results were promptly forwarded to government. Government has now requested that members formally consider their support on the following resolution:

BE IT RESOLVED THAT the College of Pharmacists of Manitoba submit a formal request to the Minister of Health, Seniors and Active Living that *The Pharmaceutical Act* be amended to repeal the requirement in section 74 of *The Act* that regulations made by the Council of the College under *The Act* must be approved by the members of the College.

Quick Facts about the Proposal to Streamline the Regulation Amendment Process

- The College's current regulation amendment process is out of alignment with almost every health profession in this province, in that members must vote to approve regulations.
- This change to *The Act* will mean that College practices will be in line with the vast majority of pharmacy regulators.
- A consultation survey sent to all 1,525 voting members indicates that 84 per cent of members who participated in the survey support this legislative proposal.

Action

Council is committed to ongoing consultation with members on any and all regulation changes, just as it has been in the past. To provide your feedback or ask questions about this proposed change to *The Act* please contact the following Council members:

president@cphm.ca (to contact Jennifer Ludwig, President); and/or
vicepresident@cphm.ca (to contact Kevin Hamilton, Vice-President).

The College encourages all members to raise their voices on this issue:

- Join us for the SGM on Monday, June 19, 2017, at St. Boniface Hospital Research Centre, 351 Tache Avenue, to discuss the proposed change to *The Act*; and
- Send your messages of support and feedback to your Council.