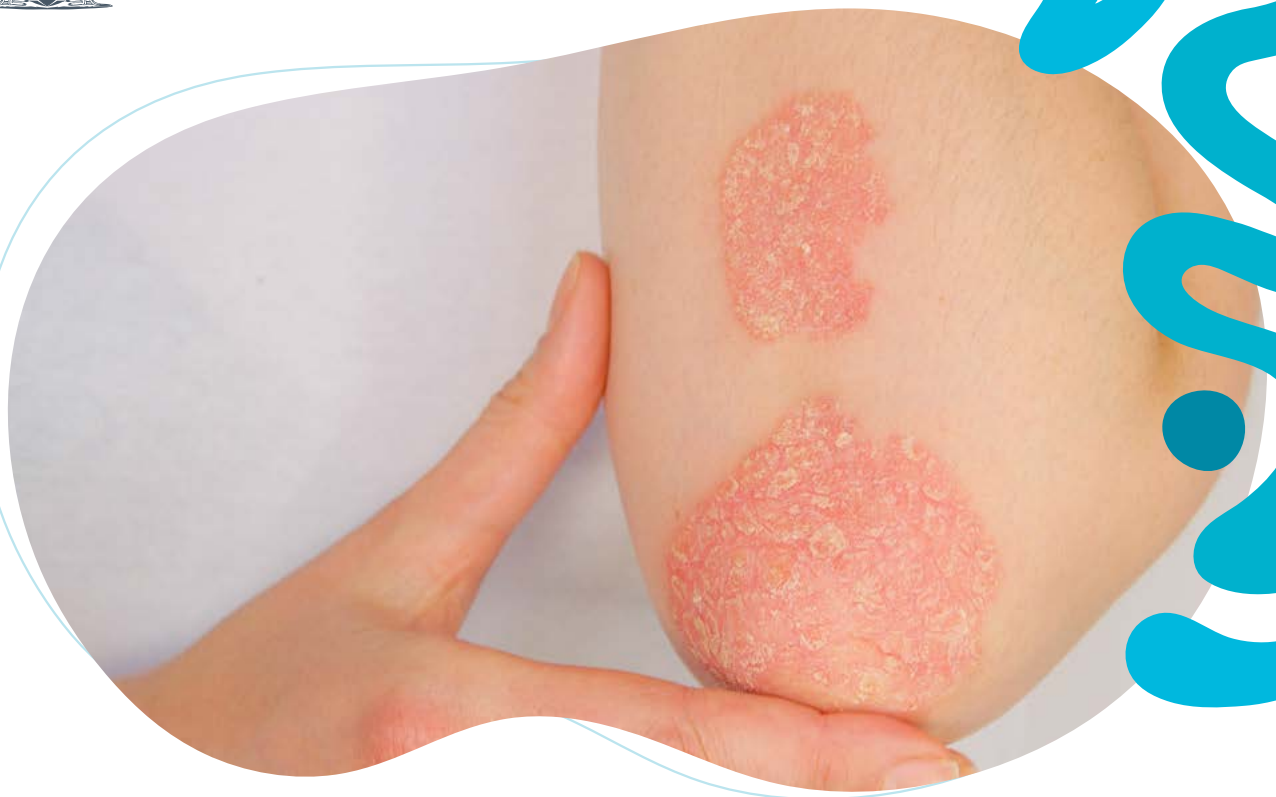
Government of **Western Australia**
Department of **Health**



# Enhanced Access Community Pharmacy Pilot

## Acute exacerbations of mild plaque psoriasis

## Clinical practice guideline

**Service restricted to patients aged 16 years or over.**

Ineligibility for treatment as part of a prescribing service does not preclude a patient from accessing services provided as part of usual pharmacy care.

The information and content in this clinical practice guideline do not constitute medical advice, diagnosis, or treatment recommendations for individual patients. Pharmacists must exercise professional discretion and judgement consistent with their qualifications and legislative authority. This guideline does not override the responsibility of the pharmacist to undertake clinical assessments and to make decisions appropriate to the circumstances of the individual and the relevant standards of care, in consultation with the patient and/or their parent/caregiver. This clinical practice guideline may only be used by pharmacists who have been approved by the Department of Health to participate in the Enhanced Access Community Pharmacy Pilot (EACPP) and are authorised to prescribe under the *Medicines and Poisons Regulations 2016* (WA). This document alone does not provide an authorisation for a pharmacist to prescribe.

## Contents

# Guideline overview

## Meet service and professional obligations

- Initial patient eligibility and suitability for management within the scope of the service
- Patient informed consent (including consent for communication with other health practitioners if relevant)

## Patient history and assessment

- Patient history:
  - aggravating factors
- Examination:
  - clinical features and severity (Psoriasis Area and Severity Index (PASI) and Dermatology Life Quality Index (DLQI))

## Develop management plan

- Non-pharmacological measures
- Pharmacotherapy:
  - topical treatments

## Confirm management is appropriate

- Contraindications, precautions, and interactions
- Pregnancy and lactation

## Communicate agreed management plan

- Medication counselling
- General advice and patient information
- When to seek further care and/or treatment
- Communication with other health practitioners

## Clinical review

- Response to treatment
- Continue, modify, or stop treatment
- Communication with other health practitioners

## Refer when

- The patient is aged below 16 years (does not preclude a patient from accessing usual pharmacy care)
- Unclear diagnosis
- Psoriatic lesions are infected
- Psoriasis is moderate or severe
- Symptoms indicate a type of psoriasis other than mild plaque psoriasis
- The face, scalp, genitals, palms, and/or soles are affected
- Inadequate response to optimal topical treatment or the condition reoccurs.

## Treat and concurrently refer

- The patient has psoriatic comorbidities or risk factors that require management
- The patient has not seen an appropriate healthcare provider for review of their condition in the previous 12 months
- The patient is taking a medicine that can exacerbate psoriasis
- Quality of life is significantly affected
- The patient is planning a pregnancy or could be pregnant
- The patient is immunocompromised.

## Key points

- People presenting with an acute exacerbation of mild plaque psoriasis (psoriasis vulgaris) may receive treatment within the service. Refer people with all other presentations to an appropriate healthcare provider.
- There is no cure for psoriasis. Treatment aims to clear lesions and manage symptoms[1]. Most cases of mild plaque psoriasis can be treated with topical therapies[2].
- Psoriasis is a systemic autoimmune disease that is associated with an increased risk of hypertension, obesity, elevated lipid levels, heart disease, diabetes, inflammatory bowel disease, lymphoma, and depression[3]. Where appropriate, consider screening for cardiovascular risk and refer if risk factors are identified that require management.
- Psoriasis can have marked functional, psychological, and social impacts, and this does not always correlate with severity[4]. Psoriasis occurring on the face, nails, scalp, genitals, flexures, and soles is considered to be severe because these areas are difficult to treat and associated with poor cosmetic outcomes[5].

## Refer when

Refer the patient to an appropriate healthcare provider (including emergency services, if required) in the following situations:

- the patient is aged below 16 years (does not preclude a patient from accessing usual pharmacy care)
- unclear diagnosis
- psoriatic lesions are infected
- psoriasis is moderate or severe
- symptoms indicate a type of psoriasis other than mild plaque psoriasis
- the face, scalp, genitals, nails, palms and/or soles are affected
- inadequate response to optimal topical treatment.

## Treat (if clinically appropriate) and concurrently refer

Provide initial treatment and concurrently refer to an appropriate healthcare provider (including emergency services, if required) in the following situations:

- the patient has psoriatic comorbidities or risk factors that require management (e.g. arthritis, risk of venous thromboembolism, depression, increased alcohol consumption, signs of lymphoma, skin cancers, and solid tumours)
- the patient has not seen an appropriate healthcare provider for review of their condition in the previous 12 months
- the patient is taking a medicine that can exacerbate psoriasis
- quality of life is significantly affected
- the patient is planning a pregnancy or could be pregnant
- the patient is immunocompromised.

# Patient history and assessment

## Patient history

Obtain sufficient information from the patient to assess the safety and appropriateness of any recommendations and medicines.

The patient history should consider:

- age
- pregnancy and lactation status (if applicable)
- onset, duration, nature, location, severity, and extent of the rash and other symptoms
- previous diagnosis of plaque psoriasis and any current or past management plan
- underlying and associated medical conditions, including psoriatic comorbidities such as arthritis (or joint pain) and common comorbidities such as hypertension, hyperlipidaemia, obesity, type 2 diabetes, and depression
- response to any previous treatment/s
- impacts on quality of life and psychosocial wellbeing
- exposure to factors that can aggravate psoriasis (see Table 1)
- current and recently ceased treatments (including prescribed medicines, vitamins, herbs, other supplements, and over-the-counter medicines)
- family history of psoriasis
- allergies/adverse drug reactions.

**Table 1: Factors that can aggravate psoriasis** [3,6,7]

| | |
|---|---|
| • Streptococcal tonsillitis (strep throat) and other infections e.g. viral<br>• Skin trauma and injuries such as cuts, abrasions, sunburn<br>• Sun exposure (although gentle exposure is often beneficial)<br>• Dry skin<br>• Obesity<br>• Metabolic factors (calcium deficiency)<br>• Smoking<br>• Sleep deprivation and emotional stress. | • Excessive alcohol consumption<br>• Hormonal factors (pregnancy or postpartum)<br>• Medicines such as lithium, beta-blockers, antimalarials, nonsteroidal anti-inflammatories, antibiotics, ACE inhibitors, terbinafine, and TNF-α inhibitors<br>• Stopping oral steroids or potent topical corticosteroids (TCS)<br>• Other environmental factors such as a stressful event. |

### Reminder

Pharmacists can access a range of clinical information in a patient's My Health Record, including details about current and past medication history, allergies, and current medical conditions.

## 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[4].
- Nail changes including 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 infections[1, 4].

### Assessment of severity

A Psoriasis Area and Severity Index (PASI) score and Dermatology Life Quality Index (DLQI) score may be used to assess severity and responses to treatment[3, 8, 9]:

- mild or mild to moderate plaque psoriasis = a PASI ≤ 10 and DLQI ≤ 10[9]
- moderate to severe plaque psoriasis = PASI > 10 and/or DLQI > 10[9]:
  - the psoriasis is always considered severe when the DLQI score is > 10, regardless of the PASI score[9].
  - it may also be considered moderate to severe if it has significant impacts on the patient'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[9, 10].

Refer to Pharmacist resources' section for more information about PASI and DLQI scores.

# Develop management plan

**Pharmacists must ensure that they are prescribing medicines according to the specified sections of the current online version of the Therapeutic Guidelines.**

Pharmacist management of acute exacerbations of mild plaque psoriasis involves:

- **non-pharmacological measures:**
  - education and advice regarding lifestyle modification, use of adjunctive agents including emollients/moisturisers, and other measures as per the Therapeutic Guidelines: Dermatology (Psoriasis - Advice for managing psoriasis in primary care) and the Australian Medicines Handbook: Psoriasis[11, 12]
- **pharmacotherapy:**
  - A topical treatment for the management of acute exacerbations of mild plaque psoriasis in accordance with the Therapeutic Guidelines: Dermatology (Psoriasis)[11].

# Confirm management is appropriate

Consult the Therapeutic Guidelines, Australian Medicines Handbook and other relevant resources to confirm that management is appropriate, including for:

- contraindications and precautions
- drug interactions
- pregnancy and lactation.

# Communicate agreed management plan

Comprehensive advice and counselling (including supporting written information when required) should be provided to the patient regarding:

- the typical cycle of psoriasis and the expectations of treatment
- individual product and medicine
- non-pharmacological measures
- how to manage adverse effects
- when to seek further care and/or treatment, including recognising infection
- when to return for follow-up.

It is the pharmacist's responsibility to ensure the suitability and accuracy of any resources and information provided to patients (and/or parents/caregivers) and compliance with all copyright conditions.

The agreed management plan should be shared with members of the patient's multidisciplinary healthcare team, with the patient's consent.

## General advice

At the time of initial consultation, patients (and/or parents/caregivers) should be advised to see an appropriate healthcare provider if:

- signs or symptoms worsen
- new signs or symptoms develop (including systemic signs or symptoms)
- the face, scalp, genitals, palms, and/or soles become affected
- they do not respond adequately to recommended treatment:
  - a 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
- quality of life is significantly affected by symptoms
- the condition reoccurs after initial resolution.

Common adverse effects of TCS including transient burning, stinging, or pain on application, can generally be reversed by stopping the medicine. Refer to an appropriate healthcare provider when adverse effects cannot be managed in the pharmacy setting.

Inconsistent use of medication and insufficient duration of treatment is a common reason for treatment failure. The patient should be advised that most treatments take between 6 to 12 weeks of consistent and correct use to start to be visibly effective[4].

# Clinical review

Clinical review with the pharmacist (or the patient's chosen healthcare provider) should occur in line with recommendations in the Therapeutic Guidelines.

Patients should return for a follow-up consultation 2 to 4 weeks after initiation of a new therapy and/or changes to the treatment plan. Clinical review should consider:

- response to treatment (and compliance)
- if changes are required to the treatment plan.

If a good response has been achieved, the medication can be reduced or stopped, and the patient can continue using regular moisturiser only. If there has been an inadequate response, the pharmacist should check the patient's compliance with the medication and skin care measures, ensuring enough medication is applied[11].

Pharmacotherapy for the management of psoriasis may be required longer-term. Pharmacists should refer the patient to an appropriate healthcare provider for review and ongoing management after the acute flare has been managed. An annual review by an appropriate healthcare provider is recommended to assess for adverse effects from TCS therapy[3, 6].

For patients continuing therapy, follow-up should be individualised to the patient's clinical presentation, response to treatment, and therapeutic goals.

Pharmacists should prescribe a quantity of medicine (including repeats) that aligns with the expected duration of therapy, ensuring sufficient supply until the patient's next review. The total quantity prescribed should not exceed 12 months supply (including repeats).

## Patient resources

- NPS MedicineWise factsheets:
  - Topical treatments for your plaque psoriasis
  - Plaque psoriasis: my options when topical treatments aren't enough
- Skin Health Institute: Psoriasis patient information

## Pharmacist resources

- Clinician Assist WA: Psoriasis
- Therapeutic Guidelines: Dermatology:
  - Psoriasis
  - Application and quantity of topical corticosteroids
  - Considerations in the use of topical corticosteroids
- Australian Medicines Handbook:
  - Drugs for psoriasis
  - General principles: topical treatment of skin conditions
  - Corticosteroids (skin)
  - Topical steroids – how much do I use?
- Australian Pharmaceutical Formulary and Handbook (APF): Treatment guideline for pharmacists (Psoriasis mild plaque psoriasis)
- DermNet NZ:
  - PASI score
  - Psoriasis
- Australian Government:
  - PASI calculation and body diagram – face, hand and foot form
  - PASI calculation and body diagram – whole body form
- Cardiff University: Dermatology Life Quality Index
- MSD Manual (Professional version): Psoriasis
- Journal of Clinical Medicine: Topographic Differential Diagnosis of Chronic Plaque Psoriasis: Challenges and Tricks
- 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: Types of psoriasis (psoriasis pictures)
- NPS MedicineWise: Plaque psoriasis
- 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 health issues in Aboriginal and Torres Strait Islander Health Peoples (an online course/ teaching resource for Aboriginal Health Workers).
- Australian Journal of General Practice: The multiple comorbidities of psoriasis.

# References


1. Shumack S, Brown P. Psoriasis. 2023. In: The A-Z of Skin [Internet]. Melbourne: The Australasian College of Dermatologists. Available from: https://www.dermcoll.edu.au/atoz/psoriasis/.
2. NPS MedicineWise. Plaque psoriasis. Surry Hills: NPS MedicineWise; 2022 [cited 2025 April 4]. Available from: https://www.nps.org.au/bdmards/dermatology#hp.
3. Clarke P. Psoriasis. Australian Family Physician. 2012;40:468-73.
4. Oakley AJ, C. Gupta, M. Psoriasis: DermNet New Zealand Trust; 2020 [cited 2022 March 8]. Available from: https://dermnetnz.org/topics/psoriasis.
5. Nair PA, Badri T. Stat Pearls: Psoriasis. Treasure Island, Florida: StatPearls Publishing; 2023 [cited 2025 April 4]. Available from: https://www.ncbi.nlm.nih.gov/books/NBK448194/.
6. Ngan V, Vather D, Oakley A. Guidelines for the managment of psoriasis: DermNet New Zealand Trust; 2020. Available from: https://dermnetnz.org/topics/guidelines-for-the-treatment-of-psoriasis.
7. Chiricozzi A. BMJ Best Practice: Psoriasis: BMJ Publishing Group; 2022 [cited 2023 August 18]. Available from: https://bestpractice.bmj.com/topics/en-gb/74.
8. Oakley A. PASI score: DermNet New Zealand Trust; 2009 [cited 2022 March 8]. Available from: https://dermnetnz.org/topics/pasi-score.
9. Foley P, Gebauer K, Sullivan J, McMeniman E, Shumack S, Ng J, et al. Treatment goals for moderate to severe psoriasis in the era of targeted therapies - Adult patients. Australasian Journal of Dermatology. 2023;64(4):476-87.
10. The Australasian College of Dermatologists. Consensus Statement: Treatment goals for psoriasis, the Australian Psoriasis Treatment Goals Project. Rhodes, NSW: The Australasian College of Dermatologists; 2017 [cited 2022 June 17]. Available from: https://atep.edu.au/wp-content/uploads/2022/07/ACD-Consensus-Statement-Treatment-goals-for-psoriasis-March-2017.pdf.
11. Therapeutic Guidelines: Dermatology (Psoriasis). Melbourne: Therapeutic Guidelines Limited; 2025 [cited 2025 April 4]. Available from: https://tgldcdp.tg.org.au/viewTopic?topicfile=psoriasis.
12. Autralian Medicines Handbook: Drugs for psoriasis. Adelaide: Australian Medicines Handbook Pty Ltd; 2025.. Available from: https://amhonline.amh.net.au/chapters/dermatological-drugs/drugs-psoriasis?menu=vertical.

## Disclaimer

All information and content in this material is provided in good faith by the Department of Health Western Australia and is based on sources believed to be reliable and accurate at the time of development and publication. While every effort has been made to ensure the accuracy of the material, no guarantee, representation, or warranty is provided of the accuracy, reliability, or suitability of any information contained in the materials. By accessing the materials, the users acknowledge and agree that the materials are intended for informational and educational purposes only and must not be relied on or used as a substitute for the user's professional judgment or own clinical assessment of patients. Users should consult relevant clinical guidelines and resources, regulatory authorities, and professional bodies, where appropriate.

To the maximum extent permitted by law, the State of Western Australia (which includes the Department of Health Western Australia, the Minister for Health, and their respective officers, employees, contractors, and agents) expressly disclaim liability (including without limitation, liability in negligence) to users or any other person for loss, damage, injury, adverse outcomes, costs, or expenses, arising from reliance on, interpretation of, or use of the materials. To the maximum extent permitted by law, the State of Western Australia makes no warranties that the materials available on or through any links provided in this publication are free of infection by computer viruses or other contamination.

## Feedback

To provide feedback on this clinical practice guideline, please email DOH.EACPP@health.wa.gov.au

This document is based on clinical guidelines/protocols originally developed by Queensland Health for the Queensland Community Pharmacy Pilots. Queensland Health is acknowledged as the source of the original material. Queensland Health does not accept responsibility for the content or accuracy of any adaptations, or for any decisions made based on the material presented in this document.

This document can be made available in alternative formats on request.

Produced by Clinical Excellence Division


CED-015081AUG'26