PREVENTIVE CARE

Herpes Zoster (Shingles)

STATEWIDE DRUG THERAPY MANAGEMENT PROTOCOL for the OREGON PHARMACIST

AUTHORITY and PURPOSE: Per ORS 689.645, a pharmacist may provide patient care services pursuant to a statewide drug therapy management protocol.

- Following all elements outlined in OAR 855-020-0110, a pharmacist licensed and located in Oregon may prescribe herpes zoster (shingles) drug regimen.

- **STANDARDIZED PATIENT ASSESSMENT PROCESS ELEMENTS:**
  - Utilize the standardized Shingles Patient Intake Form (pg. X-X)
  - Utilize the standardized Shingles Assessment and Treatment Care Pathway (pg. X-X)
  - Utilize the standardized Shingles Provider Fax (pg. X)

  PHARMACIST TRAINING/EDUCATION:
  - A minimum of 1 hour of training or continuing education (CE) on prevention and treatment of Herpes Zoster
  - Review CDC resources for healthcare providers, available at: https://www.cdc.gov/shingles/hcp/index.html

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Herpes Zoster (Shingles) Self-Screening Intake Form

(CONFIDENTIAL-Protected Health Information)

Date _____/_____/_____ Date of Birth _____/_____/_____ Age_____
Legal Name_____ Name _____
Sex Assigned at Birth (circle) M / F Gender Identification (circle) M / F / Other_____
Pronouns (circle) She/Her/Hers, He/Him/His, They/Them/Their, Ze/Hir/Hirs, Other_____
Street Address _____
Phone ( ) _____ Email Address _____
Healthcare Provider Name _____ Phone ( ) _____ Fax ( ) _____
Do you have health insurance? Yes / No Insurance Provider Name _____

Background Information:

1.	Please describe your condition by selecting the following options, if they are present: A. Rash contains cluster(s) of tiny sores with a red background …… B. Did the rash start within the last 72 hours?..... - If 72 hours have passed since the rash started, have sores continued to appear?.. C. Describe location(s) of the rash or sores:_____ □ face □ neck □ scalp □ genitals □ tip of nose □ arms/legs □ buttocks □ eye/eyelid □ stomach/chest/back - Do the rash or sores appear to be in a group near the spine or middle of your body? …… - Are the rash or sores only on the left or right side of your body?..... D. Itching, burning, tingling or pain at the site of the rash……..….. - If yes, did these symptoms occur before the rash appeared?..... E. Headache: (if yes, select one: □ mild/moderate or □ severe)…….. F. Fever: >38.8°C or >100.9°F…….. G. Changes in vision or hearing, light sensitivity, or ear pain……..	 □ Yes □ No □ Not sure □ Yes □ No □ Not sure □ Yes □ No □ N/A □ Yes □ No □ Not sure □ Yes □ No □ Not sure □ Yes □ No □ Not sure □ Yes □ No □ Not sure □ Yes □ No □ Not sure □ Yes □ No □ Not sure □ Yes □ No □ Not sure
2.	Are you under 18 years old?	□ Yes □ No
3.	Are you currently pregnant or planning to become pregnant in the next 30 days?	□ Yes □ No □ Not sure
4.	Do you have any of the following? A. A weakened immune system …… B. On kidney dialysis or being considered for dialysis ……..	 □ Yes □ No □ Not sure □ Yes □ No □ Not sure
5.	Do you have any other medical conditions? If yes, list them here: _____ _____	□ Yes □ No
6.	Have you ever been vaccinated for shingles?	□ Yes □ No □ Not sure
7.	Do you have any allergies? If yes, list them here: _____ _____	□ Yes □ No □ Not sure
8.	Do you take any medications, including herbs or supplements? If yes, list them here: _____ _____	□ Yes □ No □ Not sure

Signature_____ Date_____

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Herpes Zoster (Shingles) Assessment and Treatment Care Pathway

Name: _____Date of Birth: ____/____/_____ Today's Date: ____/____/_____

<table>
<tr><td colspan="2">1A. Does the patient report that the rash appears to be cluster(s) of tiny sores with a red background?</td><td rowspan="2">Notes: Patient is describing a rash consistent with shingles</td></tr>
<tr><td>□ Yes: Go to #1B.</td><td>□ No: Do not prescribe Antiviral therapy. Advise patient to seek healthcare from a non-Pharmacist provider</td></tr>
<tr><td colspan="2">1B. Did the rash start within the last 72 hours or if 72 hours have passed since the rash started, have sores continued to appear?</td><td rowspan="2">Notes: Shingles treatment is time sensitive with evidence supporting use < 72 hours from time of visual rash. Many experts recommend treatment after 72 hours if sores are continuing to appear.</td></tr>
<tr><td>□ Yes: Go to #1C.</td><td>□ No: Do not prescribe Antiviral therapy. Refer patient to local primary care provider (PCP), emergency department (ED), urgent care, or public health clinic.</td></tr>
<tr><td colspan="2">1C. Does the rash appear in both sides of the body or in multiple dermatomes or is it located in a concerning area that includes the face, neck, scalp, genitals, tip of nose, eye/eyelid?</td><td rowspan="2">Notes: If applicable, counsel patient that a rash appearing on the face, neck, scalp, genitals, tip of nose or eye/eyelid are at high risk for permanent complications and need close monitoring. Bilateral or multiple dermatome involvement may represent disseminated herpes zoster and require more aggressive treatment.</td></tr>
<tr><td>□ Yes: Do not prescribe Antiviral therapy. Refer patient to emergency department (ED) or urgent care.</td><td>□ No: Go to #1D.</td></tr>
<tr><td colspan="2">1D. Did the patient experience itching, burning, tingling or pain at the site of the rash that was not present beforehand?</td><td rowspan="2">Notes: Shingles has a characteristic 'prodrome' period that commonly exhibits these symptoms.</td></tr>
<tr><td>□ Yes: Go to #1E.</td><td>□ No: Go to #1E.</td></tr>
<tr><td colspan="2">1E. Has the patient experienced headache? If yes, is the headache mild/moderate or severe?</td><td>Notes:</td></tr>
<tr><td>□ Yes: Go to #1F. If the headache is severe provide timely treatment as appropriate and refer patient to local primary care provider (PCP), urgent care, or public health clinic. If very severe, refer to emergency department (ED).</td><td>□ No: Go to #1F.</td><td></td></tr>
<tr><td colspan="2">1F-1G. Does the patient present with any of the following?
□ Fever >38.8°C or >100.9°F
□ Changes in vision or hearing, light sensitivity, or ear pain</td><td>Notes:</td></tr>
<tr><td>□ Yes: Do not prescribe antiviral therapy. Refer patient to emergency department (ED) or urgent care</td><td>□ No: Go to #2</td><td></td></tr>
<tr><td colspan="2">2. Is the patient less than 18 years old?</td><td rowspan="2">Notes:</td></tr>
<tr><td>□ Yes: Do not prescribe Antiviral therapy. Refer patient to local primary care provider (PCP), emergency department (ED), urgent care, or public health clinic.</td><td>□ No: Go to #3</td></tr>
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Herpes Zoster (Shingles) Assessment and Treatment Care Pathway

<table>
<tr><td colspan="2">3. Is the patient currently pregnant or planning to become pregnant within 30 days?</td><td rowspan="2">Notes:</td></tr>
<tr><td>□ Yes, or Not Sure: Do not prescribe Antiviral therapy. Refer patient to local primary care provider (PCP), emergency department (ED), urgent care, or public health clinic.</td><td>□ No: Go to #4A</td></tr>
<tr><td colspan="2">4A. Does the patient have any medical condition(s) that cause them to be immunocompromised (e.g. HIV, transplant recipient on aggressive antirejection therapy, cancer, etc.)</td><td rowspan="2">Notes:</td></tr>
<tr><td>□ Yes: Caution patient on risk of disseminated zoster. Recommend follow-up with local primary care provider (PCP), emergency department (ED), urgent care, or public health clinic. Go to #4B.</td><td>□ No: Go to #4B</td></tr>
<tr><td colspan="2">4B. Is the patient on kidney dialysis or being considered for dialysis?</td><td rowspan="2"></td></tr>
<tr><td>□ Yes: Do not prescribe Antiviral therapy. Refer patient to local primary care provider (PCP), emergency department (ED), urgent care, or public health clinic.</td><td>□ No or not sure: Go to #5</td></tr>
<tr><td colspan="2">5. Does the patient have any other medical conditions that have contraindications to receiving antiviral treatment?</td><td rowspan="2">Notes:</td></tr>
<tr><td>□ Yes: Do not prescribe Antiviral therapy. Refer patient to local primary care provider (PCP), emergency department (ED), urgent care, or public health clinic.</td><td>□ No: Go to #6</td></tr>
<tr><td colspan="2">6. Is the patient fully vaccinated with the current CDC recommended shingles vaccine?</td><td rowspan="2">Notes: If the patient is eligible and not fully vaccinated with the current CDC recommendation, recommend the patient to start/complete series once symptoms are resolved and properly spaced (14 days) from antiviral therapy.</td></tr>
<tr><td>□ Yes: Go to #7</td><td>□ No: Go to #7</td></tr>
<tr><td colspan="2">7. Does the patient have hypersensitivity to acyclovir, valacyclovir, famciclovir, or any component of one of these medications?</td><td rowspan="2">Notes:</td></tr>
<tr><td>□ Yes: Do not prescribe Antiviral therapy. Refer patient to local primary care provider (PCP), emergency department (ED), urgent care, or public health clinic.</td><td>□ No: Continue to #8</td></tr>
<tr><td colspan="2">8. Does the patient take any medications, including non-prescription drugs, herbs or supplements that have known contraindications with antiviral treatment?</td><td rowspan="2">Notes:</td></tr>
<tr><td>□ Yes: Do not prescribe Antiviral therapy. Refer patient to local primary care provider (PCP), emergency department (ED), urgent care, or public health clinic.</td><td>□ No: Complete patient encounter and proceed to treatment regimen.</td></tr>
</table>

Herpes Zoster (Shingles) Assessment and Treatment Care Pathway

RECOMMENDED REGIMEN: May prescribe for up to two 7-day treatment per rolling 12-month period	
□ Valacyclovir 1000mg	Take one tablet by mouth three times a day for 7 days #21 + 0 refills
□ Famciclovir 500mg	Take one tablet by mouth three times a day for 7 days #21 + 0 refills
□ Acyclovir 800mg	Take one tablet by mouth five times a day for 7 days #35 + 0 refills

□ Recommend oral OTC analgesics for pain.

□ Recommend Zoster vaccination after the acute stage of the illness is over and symptoms abate.

□ Future Zoster vaccination not recommended.

RPH Signature_____ RPH Name (Print)_____ Date: _____

COUNSELING POINTS:

- Antiviral medications: side effects that may be seen with valacyclovir, famciclovir, and acyclovir are headache, nausea, vomiting, dizziness, and abdominal pain. Please refer to the medication guide that was provided with the medication you were prescribed for additional information.
    - **NOTE:** Drink plenty of water while taking any of these antiviral drugs.
    - Initiation within 72 hours of onset of rash may relieve symptoms, speed healing, and prevent/lessen postherpetic neuralgia (PHN).
- OTC pain management:
    - Non-Steroidal Anti-Inflammatory Drugs (NSAIDS): This drug class includes ibuprofen (Advil or Motrin) and naproxen (Aleve), among others. Their most common side effects are upset stomach, increased risk of bleeding, stomach bleeds, headache, fluid retention, worsening of chronic kidney disease, and worsening of congestive heart failure. If in severe pain or pain worsens, refer to other healthcare provider.
    - Acetaminophen: Do not take more than 3,250mg per day (from all products) and avoid alcoholic beverages while taking acetaminophen.
- Zoster vaccine: Recommend initial vaccination upon visual clearance of rash for protection against any potential future reactivation of Herpes Zoster. If patient previously fully vaccinated according to current CDC recommendations, no additional vaccination is permitted per OHA immunization protocol.
- Patients who have never had chickenpox or the chickenpox vaccine can develop chickenpox if they come in direct contact with the rash from the time it forms blisters until it crusts over.
- Patients who provide care to persons who are immunocompromised or pregnant should remain isolated from such persons.
- Rash:
    - Keep the rash clean and dry.
    - If wounds are open, cover the sores. Do not apply any topical analgesics to open sores.
    - Explain that the duration of the rash is typically 2-3 weeks, but pain may persist.
    - Warn that appearance of a disseminated rash requires immediate medical care. Lesions that cross the midline, are not unilateral, and/or have spread to more than 2 dermatomes (indicates the patient may be immunosuppressed).
    - Warn that sores in the areas of high concern □ face □ neck □ scalp □ genitals □ tip of nose □ eye/eyelid need to be urgently evaluated by a non-Pharmacist healthcare provider.
- If >1 episode of zoster per lifetime, follow-up with a healthcare provider as appropriate (i.e. could be herpes simplex, patient may be immunosuppressed).
- Postherpetic Neuralgia (PHN) may occur, especially if >50 years old, despite antiviral treatment. Patient may consider topical analgesics (capsaicin, lidocaine, etc.) if this occurs and all lesions are cleared.
- Instruct patient to contact PCP if any of the following occur
    - New vesicles appear more than 1 week after rash onset
    - An allergic reaction to the medications prescribed is seen
    - Rash worsens
    - Development of a fever
    - Rash spreads to other parts of the body

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Herpes Zoster (Shingles) Assessment and Treatment Care Pathway

PHARMACIST MANDATORY FOLLOW-UP (5 days after initial visit):

1. How are you feeling? _____
2. Are your symptoms better/worse/same? _____
3. Are you having any new lesions, spreading of the rash, or new or worsening symptoms including fever or pain?

   _____
4. How have you been using your medications for shingles? _____
5. What adverse reactions have you experienced, if any? _____
6. If not fully vaccinated, a Zoster vaccine is recommended after the acute stage of the illness is over and symptoms abate.
7. What questions/concerns do you have for me? _____

Additional notes:

_____

_____

Changes/updates to regimen:

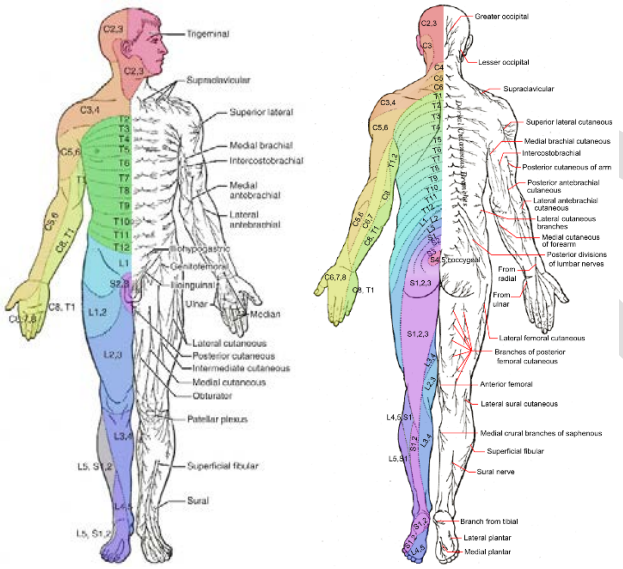
□ Referred to prescriber due to change in symptoms or other reasons:

_____

□ Unable to contact/attempts made:

_____

Pharmacist Signature_____Date____/____/_____



The shingles rash commonly presents in one or more thoracic dermatomes (labeled in green), typically on one side of the body. However, the rash can also present in multiple dermatomes, including the face, and in rare instances, appear on both sides of the midline.

Images: Häggström, Mikael (2014). "Medical gallery of Mikael Häggström 2014". *WikiJournal of Medicine* **1** (2). DOI:10.15347/wjm/2014.008. ISSN 2002-4436. Public Domain.

References:

Valacyclovir. Lexi-Drugs. Lexicomp. Wolters Kluwer Health, Inc. Riverwoods, IL. Available at: https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/7849?cesid=96ONN2zDaek&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3Dvalacyclovir%26t%3Dname%26va%3Dvalacyclovir Accessed July 9, 2021.

Famciclovir. Lexi-Drugs. Lexicomp. Wolters Kluwer Health, Inc. Riverwoods, IL. Available at: https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/6893?cesid=7Y0tk9FO6ns&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3Dfamciclovir%26t%3Dname%26va%3Dfamciclovir Accessed July 9, 2021.

Acyclovir. Lexi-Drugs. Lexicomp. Wolters Kluwer Health, Inc. Riverwoods, IL. Available at: https://online.lexi.com/lco/action/doc/retrieve/docid/patch_f/6893?cesid=7Y0tk9FO6ns&searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3Dfamciclovir%26t%3Dname%26va%3Dfacyclovir Accessed July 9, 2021.

Herpes Zoster (Shingles) Prescription

Optional-May be used by pharmacy if desired

Patient Name:	Date of birth:
Address:	
City/State/Zip Code:	Phone number:

☐ Verified DOB with valid photo ID

Rx

☐ **Valacyclovir 1000mg**
- Take one tablet by mouth three times a day for 7 days, #21, 0 refills

-or-

☐ **Famciclovir 500mg**
- Take one tablet by mouth three times a day for 7 days, #21, 0 refills

-or-

☐ **Acyclovir 800mg**
- Take one tablet by mouth five times a day for 7 days, #35, 0 refills

Written Date: _____

Expiration Date: _____

Prescriber Name: _____Prescriber Signature: _____

Pharmacy Address: _____ Pharmacy Phone: _____

-or-

☐ Patient Referred

Notes:_____
_____
_____
_____

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Provider Notification

Antiviral Therapy for Herpes Zoster (Shingles)

(CONFIDENTIAL-Protected Health Information)

Pharmacy Name:_____
Pharmacy Address:_____
Pharmacy Phone:_____ Pharmacy Fax: _____

Your patient _____(name) _____/_____/_____ (DOB) was:

☐ **Prescribed antiviral therapy for shingles management** at our Pharmacy on _____/_____/_____ as noted above. The prescription issued and dispensed consisted of:

- □ Valacyclovir 1000mg Take one tablet by mouth three times a day for 7 days, #21 + 0 refills
- □ Famciclovir 500mg Take one tablet by mouth three times a day for 7 days, #21 + 0 refills
- □ Acyclovir 800mg Take one tablet by mouth five times a day for 7 days, #35 + 0 refills

☐ **Referred to**:

☐ Primary care provider (PCP) ☐ Emergency department (ED) ☐ Urgent care ☐ Public health clinic and not prescribed to your patient for the following reasons:

_____
_____
_____
_____
_____

The prescription was issued pursuant to the Board of Pharmacy protocol authorized under OAR 855-020-0300. During the visit the pharmacist integrated patient-specific information and disease-state knowledge to provide treatment and/or referral to another provider for further assessment. During this visit we carefully reviewed the patient's medical, prescription history, and lifestyle factors to ensure the safety of the patient and appropriateness of therapy.

RPH Signature_____ RPH Name (Print)_____ Date: _____

Please contact us if you have any questions about the care provided to our mutual patient or if you would like to obtain additional information. Please contact prescribing pharmacy.

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