Clinical Sub-Group to support the delivery of an Expanded Role for Community Pharmacy

Common Conditions Service Protocol

Shingles (Final)

V1.2 26/09/2025

This protocol does not impede the sale and supply of medicines 'over the counter' where this legal route of supply is relevant

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1. Critical Elements

1.1 Protocol Version
Version 1.2
1.2 Protocol Authors
Clinical Sub-Group to support the delivery of an Expanded Role for Community Pharmacy (See Appendix A for membership)
• Pharmacists wishing to deliver this service must: 1. Complete the mandatory Common Conditions Service training. Training can be accessed on the Irish Institute of Pharmacy website. 2. Adhere to the information and recommendations included in the Clinical Protocol for this common condition, and always ensure that they are following the current version of the protocol. Current versions of the Clinical Protocols can be accessed on the HSE website. 3. Comply with legislation in place that relates to delivery of the service and any associated guidance from the PSI. • NOTE: Locum pharmacists employed on a temporary basis who have successfully completed the training may be authorised to provide the service. They must be able to produce a record of their training upon request.

2. Clinical Criteria

2.1 Clinical condition for use of the protocol and differential diagnosis

Shingles (Herpes Zoster)

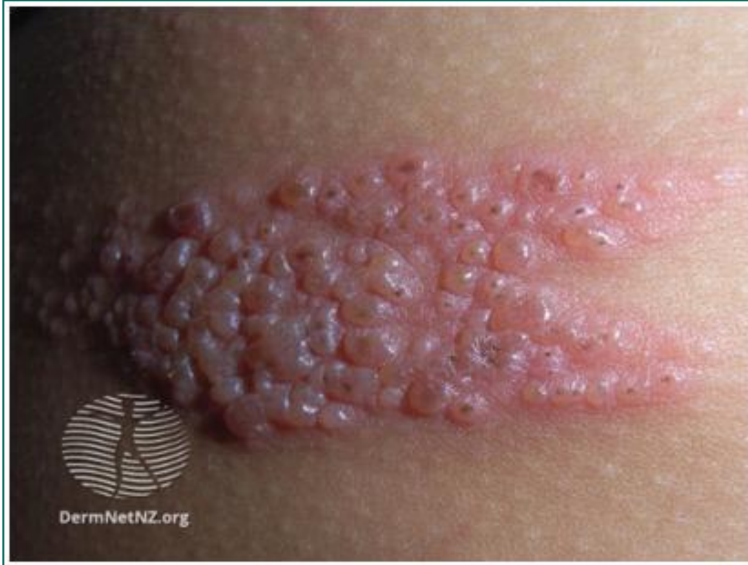
Background
Herpes zoster infection is due to reactivation of the latent varicella zoster virus. Individuals will have been previously infected with the primary infection of varicella (chickenpox). The virus remains dormant in the sensory dorsal root ganglia for years before it is reactivated. The reactivated virus travels down sensory nerves to the skin and is usually localised to a specific nerve distribution. The shingles rash manifests in the dermatome, which is the area of skin innervated from the affected dorsal root ganglia. Herpes zoster can occur at any age but is usually more common in older people or individuals who are immunocompromised.

Signs and Symptoms
Prodromal Phase:
The initial signs of shingles are most commonly an abnormal skin sensation and dermatomal pain (pain in the area of skin arising from the nerve root involved). This prodromal phase is ordinarily present between 48 to 72 hours before the subsequent skin lesions (rash) develops.

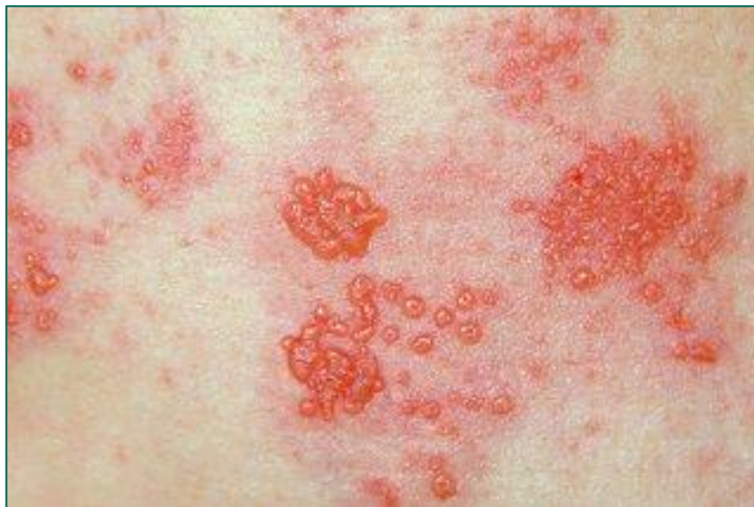
The nerve pain identified during the prodromal phase can be constant or intermittent and is frequently described as a stabbing, prickling, burning or throbbing sensation. Further abnormal skin sensations identified during this phase include itching, paraesthesia (numbness / pins and needles sensation) and hyperesthesia (sense of touch is overly sensitive). The pain may be just in one spot, or it may spread out. The individual may also report feeling quite unwell (malaise) with fever and headache. The lymph nodes draining the affected area may be tender and swollen. Other symptoms such as fatigue and photophobia may also occur as part of the prodromal phase.

Rash:
Within days, a unilateral vesicular (fluid filled blisters) rash typically appears in a dermatomal distribution - that is the blisters are confined to the cutaneous distribution of one or two adjacent sensory nerve roots. This usually presents as the ‘classic’ rash of shingles which occurs in one or two adjoining dermatomes and stops sharply at the midline. The exception to this is in immunocompromised individuals, where a rash involving multiple dermatomes may occur.

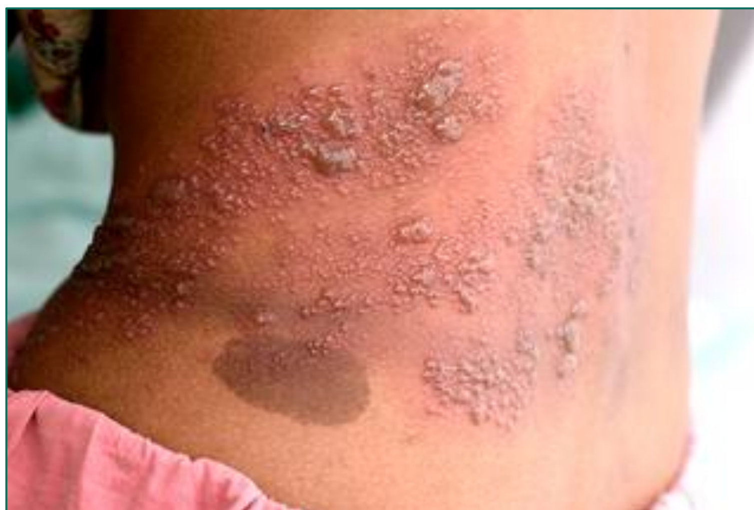
The rash initially presents as a crop of red papules, which then develop into fluid filled vesicles (blisters). These vesicles scab and crust over within seven to ten days. New vesicles may continue to appear within the locality of the affected nerve, for up to one week. The rash affected area may be very painful with abnormal skin sensations such as paraesthesia or itching, which will gradually subside. In some circumstances, the rash may present without pain. It can take up to four weeks for the rash to heal. The thoracic and lumbar dermatomes are most commonly affected, but the rash can develop in any dermatome.



Close-up of Herpes Zoster blisters (HSE Antibiotic Prescribing, Source: DermNetNZ.org)

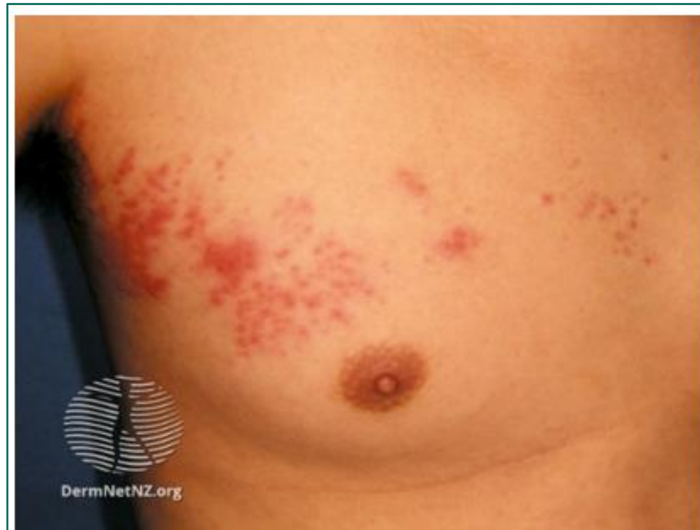


The blotches become itchy blisters that ooze fluid. A few days later, the blisters dry out and crust over (HSE A-Z)

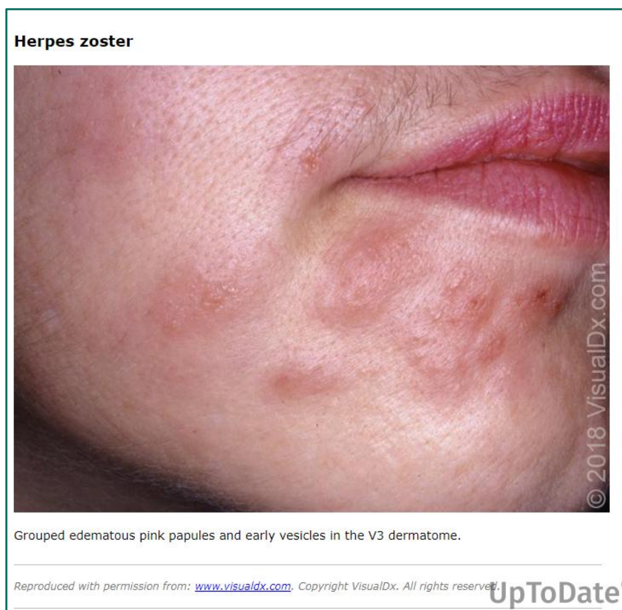


The rash can be red, but this can be harder to see on brown and black skin (HSE A-Z)

The rash can form a cluster that only appears on one side of the body. The skin remains painful until after the rash has gone (HSE A-Z)



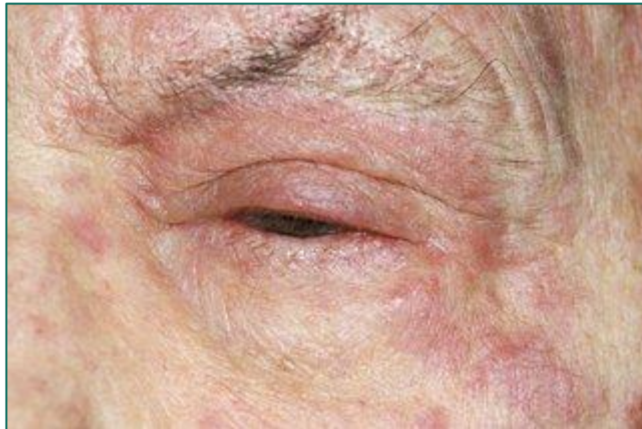
Herpes Zoster on the chest (HSE Antibiotic Prescribing, Source: DermNetNZ.org)



Herpes Zoster (UpToDate®)

Complications of Herpes Zoster for referral:
Herpes zoster occasionally causes:

- Blisters inside the mouth, ears or the genital area.
- Ramsay Hunt Syndrome (Herpes zoster oticus).
  Caused by a reactivation of the varicella zoster virus affecting the facial nerve and less commonly other cranial nerves. Symptoms may include:
  - Facial paralysis.
  - Ear pain.
  - Hearing abnormalities (hearing loss, tinnitus, hyperacusis which is a reduced tolerance to sound).
  - Fluid filled blisters in the auditory canal or on the auricles with or without facial paralysis.
  - Vestibular disturbances (vertigo).
  - Altered taste sensation.
  - Hoarseness or aspiration.
  - Throat may be affected due to vagus nerve involvement.
- Herpes zoster ophthalmicus
  Potentially sight threatening complication caused by infection of the trigeminal nerve. Symptoms may include:
  - Hutchinson's sign (vesicular lesions on the side or tip of the nose).
  - Blistering rash around the eye or eyelid.
  - Pain, swelling and redness around the eye.



Shingles affecting the eye (HSE A-Z)

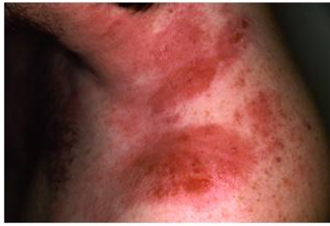
Individuals presenting with any of the above complications require referral (as detailed in Section 2.4).

Differential Diagnosis:

Contact dermatitis

Contact dermatitis can be caused by contact with irritants or allergens. Symptoms are usually localised to the area of exposure and may include red irritated, itching, stinging or blistered skin in the area exposed to the allergen or irritant. The reaction usually occurs within a few hours or days of exposure to the allergen or irritant.

Allergic contact dermatitis

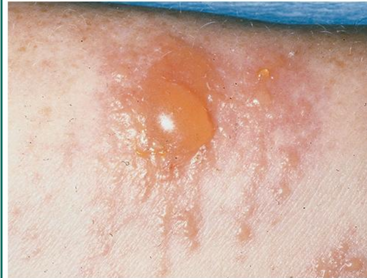


Allergic contact dermatitis is characterized by an erythematous, papular dermatitis with indistinct margins, distributed in areas of exposure.

Courtesy of James C Shaw, MD. UpToDate®

Allergic contact dermatitis (UpToDate ®)

Allergic contact dermatitis



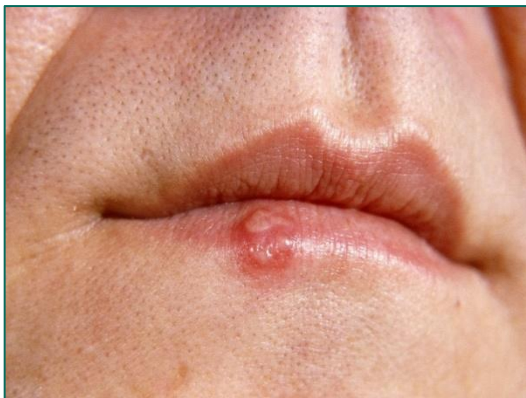
Vesicles and bullae developed on the volar forearm after application of perfume.

Reproduced with permission from: Elder AD, Elenitsas R, Johnson BL, et al. Synopsis and Atlas of Lever's Histopathology of the Skin, Lippincott Williams & Wilkins, Philadelphia 1999. Copyright © 1999 Lippincott Williams & Wilkins. UpToDate®

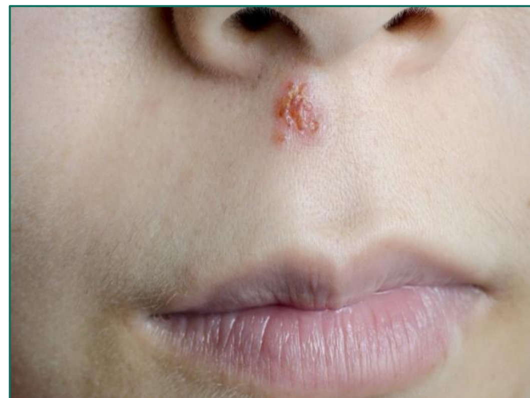
Allergic contact dermatitis (UpToDate ®)

Cold Sores – Herpes Simplex Virus (HSV)

Small, fluid-filled blisters are the main HSV symptom in adults and children. Cold sores usually start with a tingling, itching or burning feeling (prodromal phase). Over 48 hours, blisters may appear, weep and usually crust over into a scab. Lymph nodes may be swollen and tender.



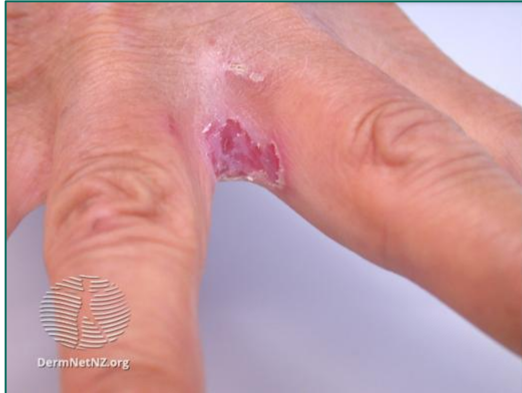
Small fluid-filled blisters appear (HSE A-Z)



The blisters can appear anywhere on the face (HSE A-Z)

Candidal skin

Cutaneous *Candida* infection is a fungal infection that commonly infects the skin and requires topical therapy. It commonly affects genital and nappy areas, skin folds, oral, and nail area. It can also present as a secondary infection, particularly in individuals with existing skin conditions such as psoriasis.

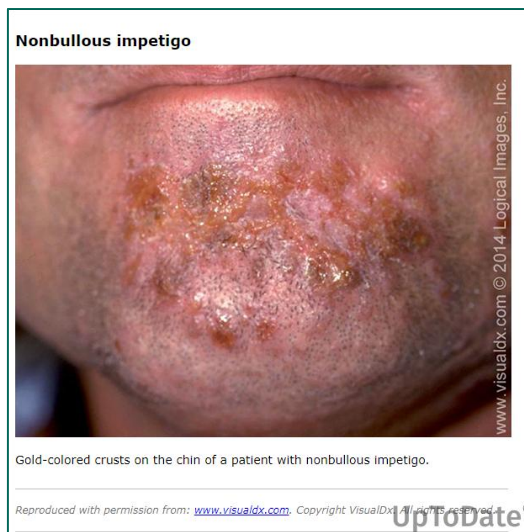


Cutaneous candidiasis (HSE Antibiotic Prescribing, Source DermNetNZ.org)

Cutaneous candidiasis (HSE Antibiotic Prescribing, Source DermNetNZ.org)

Non-bullous impetigo

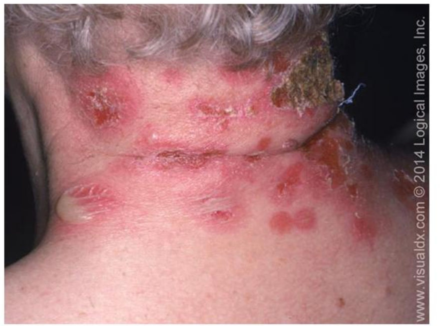
Non-bullous impetigo is the most common form of impetigo. It usually presents around the nose and mouth but may affect other extremities including the limbs and flexures. The symptoms of non-bullous impetigo begin with the appearance of small erythematous macule (a flat, discoloured area of skin). Vesicles (blisters) then appear as fluid filled lesions (less than 0.5cm in diameter). The blisters burst leaving behind thick, honey-coloured crusts typically around 2cm in diameter. Once the crusts dry, they leave a red mark which usually disappears within a few days or weeks, without leaving a scar. These lesions are not painful. There may be some itching in the area and individuals should be counselled to avoid scratching or touching the areas as they may spread the infection to other parts of the body (autoinoculation), and to other people. In more severe cases of infection symptoms may include swollen glands and fever.



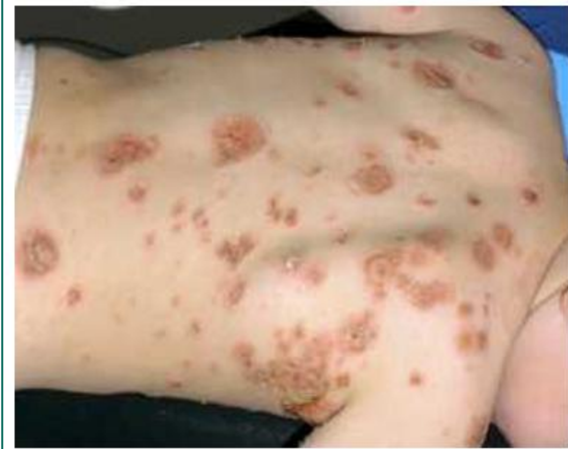
Non-bullous impetigo (UpToDate ®)

Bullous impetigo

In bullous impetigo, symptoms begin with the appearance of the bullae (large, flaccid, fluid filled blisters) which are usually 1cm to 2cm in diameter. These blisters are filled with yellow/clear fluid, spread rapidly, and may present with pain and itching in the affected area(s). It most commonly affects the trunk, neck, arms, and legs. Individuals are more likely to present with fever or swollen glands with this type of impetigo. Once the blisters burst, they leave a yellow crust which typically heals without scarring over days and weeks. Individuals should be counselled to avoid touching the area.



Bullous impetigo (UpToDate ®)



Widespread bullous impetigo over the back (HSE Antibiotic Prescribing)

Insect bite or sting

The main symptoms of an insect bite or sting are:

- pain or feeling itchy where the individual was bitten or stung.
- a swollen lump on the skin.
- some bites or stings may result in fluid-filled blisters.

The lump may look red and may be more difficult to see on black or brown skin. Different insect bites and stings will cause different symptoms – refer to HSE A-Z for images and symptoms.

Urticaria (Hives)

Hives are a very common skin condition characterised by raised, itchy bumps on the skin that appear like a rash. They may present in different sizes and shapes, appear anywhere on the body in both adults and children, and tend to move around on the body and appear elsewhere in 24 hours. In some cases, there may be swelling of the subcutaneous or submucosal tissue (angio-oedema). It is typically spontaneous but may be triggered from contact with an allergen, change in physical environment (exposure to sunlight or cold), medications (e.g. penicillin allergy) or may be symptomatic of other underlying medical conditions. It is usually self-limiting within a few minutes to a few days depending on the cause. Individuals should be advised to avoid continued exposure to known triggers and to seek further medical advice if the condition persists or reoccurs.

The rash can also be red spots (HSE A-Z)

2.2 Summary of Clinical Features

- The initial signs of shingles are most commonly an abnormal skin sensation and dermatomal pain (pain in the area of skin arising from the nerve root involved). This prodromal phase is ordinarily present between 48 to 72 hours before the subsequent skin lesions (rash) develops.
- The nerve pain identified during the prodromal phase can be constant or intermittent and is frequently described as a stabbing, prickling, burning or throbbing sensation.
- The individual may also report feeling quite unwell (malaise) with fever and headache.
- Within days, a unilateral vesicular (fluid filled blisters) rash typically appears in a dermatomal distribution - that is the blisters are confined to the cutaneous distribution of one or two adjacent sensory nerve roots. The ‘classic’ rash of shingles occurs in one or two adjoining dermatomes and stops sharply at the midline. The exception to this is in immunocompromised individuals, where a rash involving multiple dermatomes may occur.
- The rash initially presents as a crop of red papules, which then develop into fluid filled vesicles (blisters).
- These vesicles scab and crust over within seven to ten days. New vesicles may continue to appear within the locality of the affected nerve, for up to one week.
- It can take up to four weeks for the rash to heal.

2.3 Inclusion criteria

2.3.1 CRITERIA FOR INCLUSION

- Informed consent given.

AND

- Individual with shingles presenting **within 72 hours of onset of rash in all individuals over 50 years of age** (to reduce risk of post-herpetic neuralgia).

OR

- Individual with shingles presenting **within 72 hours of onset of rash for individuals 18 to 49 years of age with any of the following**:
  - Rash affecting arms, legs, or neck.
  - Moderate or severe pain (pain not controlled with simple over-the-counter (OTC) analgesia).
  - Moderate or severe rash.

OR

- Individual with shingles presenting **up to one week after onset of rash for individuals aged 18 or over with any of the following**:
  - Aged 70 years and over.
  - Continued vesicle formation.
  - Severe pain.

OR

- Pharmacists can **consider prescribing an initial limited supply of treatment <u>if clinically appropriate</u>**, to mitigate the risk of delay in access to treatment, for an **individual aged 18 or over** with shingles, meeting the criteria set out in **Section 2.4.2** or **Section 2.4.4**. Treatment should be limited to the dose or time necessary for an individual to access the referral pathway.

2.4 Exclusion criteria and Referral Pathways

2.4.1 CRITERIA REQUIRING EMERGENCY REFERRAL TO HOSPITAL EMERGENCY DEPARTMENT/CONTACTING EMERGENCY SERVICES

- Individual is systemically very unwell, or showing symptoms of severe/life-threatening infection, or systemic sepsis: **Refer urgently to Emergency Department (ED) via ambulance.**
- Suspected Meningitis (mottled skin, neck stiffness, photophobia).
- Presence of neurological symptoms which may indicate encephalitis (disorientation/confusion/behavioural changes).
- Muscle weakness, loss of bladder or bowel control (risk of Myelitis).
- Facial nerve paralysis (may indicate stroke instead of shingles or Ramsay Hunt syndrome).
- Individual has double vision, ptosis (lid droop) or enlarged pupil that need to be urgently referred to the Hospital Emergency Department – these are signs of a cranial nerve palsy and can indicate CNS involvement (central nervous system) and need input from a hospital physician.

2.4.2 CRITERIA REQUIRING URGENT MEDICAL ASSESSMENT (TREATING SERVICE/GENERAL PRACTITIONER/GENERAL PRACTITIONER OUT OF HOURS/HOSPITAL EMERGENCY DEPARTMENT) – INITIAL LIMITED SUPPLY*

***Pharmacists can consider prescribing an initial limited supply of treatment <u>if clinically appropriate</u> to mitigate the risk of delay in access to treatment. Treatment should be limited to the dose or time necessary for an individual to access the referral pathway.**

- Suspected shingles in the ophthalmic distribution of the trigeminal nerve (Herpes zoster ophthalmicus), especially with: Hutchinson's sign (vesicular lesions on the side or tip of the nose) **OR** Visual symptoms **OR** an unexplained red eye. Assessment within 24 to 48 hours by an ophthalmologist is recommended. Individuals should be directed to contact their GP or emergency services to access the regional eye unit ED service. Individuals should be advised on the importance of this follow-up.
- Individual has suspected Ramsay Hunt Syndrome (Herpes zoster oticus) with or without the presence of an auricular rash, but absence of facial weakness.
- Individual has moderate to severe immunocompromise due to underlying medical conditions or treatments. If a pharmacist is uncertain about the extent of immunocompromise or suitability of treatment, they should seek advice from or refer to the treating physician.
- Individual has a rash that is widespread or severe or individual is systemically unwell.
- Individual has a high risk of severe shingles due to severe atopic dermatitis/eczema or the individual presents with skin lesions that have signs of secondary infection with a risk of superinfection.
- Disseminated Zoster.

2.4.3 CRITERIA REQUIRING REFERRAL TO GENERAL PRACTITIONER or OTHER RELEVANT MEDICAL PRACTITIONER

Note: Pharmacist prescribing not permitted

- Individuals under 18 years of age.
- Contraindications as specified in the medication Summary of Product Characteristics.
- Pregnancy or suspected pregnancy (refer to GP/treating obstetrician/gynaecologist).
- Over seven days since vesicle formation.
- Breastfeeding.
- Diagnosis is unclear, including atypical cutaneous presentations.
- Failure to respond to treatment with antiviral for this episode of shingles or there is a deterioration in symptoms.
- Known hypersensitivity or adverse reaction to medication treatment options as included in Section 3.1, or any of the components within the formulation.
- Individuals at risk of dehydration and unable to maintain adequate fluid intake.
- Individuals unable to swallow or absorb oral medications.
- Individuals taking medication which interacts with anti-viral treatment.
- Antiviral treatment is appropriate but falls outside scope of this protocol.
- Individual recently started new medication and suspected drug-induced rash.
- Individual has had a previous Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS) to treatment with Valaciclovir. Treatment must not be restarted in this individual at any time.

2.4.4 CRITERIA REQUIRING REFERRAL TO GENERAL PRACTITIONER or OTHER RELEVANT MEDICAL PRACTITIONER – INITIAL LIMITED SUPPLY*

***Pharmacists can consider prescribing an initial limited supply of treatment <u>if clinically appropriate</u> to mitigate the risk of delay in access to treatment. Treatment should be limited to the dose or time necessary for an individual to access the referral pathway.**

- Recurrent shingles – recurrent infection within six months of a previous episode.
- Rash involving more than two separate dermatomes and/or crosses the body's midline.
- Individual is immunocompromised due to underlying medical conditions or treatments (excluding those with moderate to severe immunocompromise: see Section 2.4.2).
- Individual previously vaccinated against herpes zoster infection.
- Current long-term use of oral antiviral medication as included in Section 3.1 (e.g. for prophylaxis of HSV infection etc.) – consider individual may need switch to therapeutic dose
- Suspected shingles rash affecting genital area.
- Other complications of shingles suspected including pneumonia or scarring.
- Pain inadequately controlled with over-the-counter analgesia or requiring pain management for moderate to severe pain associated with post-herpetic neuralgia.

2.5 Action to be taken where individual meets exclusion criteria, or treatment is not indicated, or if the individual/parent/legal guardian declines treatment
• If individual meets exclusion criteria, they should be referred or signposted as per the protocol (see Section 2.4). • Advise individual/parent/legal guardian to seek medical advice if symptoms deteriorate. • Signpost to available resources on HSE A-Z and the HSE app if appropriate. • Follow record keeping procedures.

3. Details of medication

3.1 Name of medication, dose, and duration

Treatment Options & Formulary

Shingles Oral Antiviral Treatment (Adults)

Drug	Available Preparations	Dose	Duration	Notes
1st Line Option				
Valaciclovir	250mg or 500mg Tablets	1g orally every 8 hours	7 Days **If immunocompromised:** continue for 2 days after crusting of lesions	Dose reduction in renal impairment (see Appendix B) See Section 2.4 for immunocompromised individuals (Pharmacists can consider prescribing an initial limited supply of treatment if clinically appropriate to mitigate the risk of delay in access to treatment. Treatment should be limited to the dose or time necessary for an individual to access the referral pathway.)
2nd Line Option (if 1st line option is not available or is unsuitable)				
Aciclovir	200mg or 800mg Dispersible Tablets 200mg/5ml or 400mg/5ml Oral Suspension	800mg orally Five Times Daily Doses to be taken five times a day at approximately 4 hourly intervals, during waking hours.	7 Days **If immunocompromised:** continue for 2 days after crusting of lesions.	Dispersible Tablets and Liquid Available Dose reduction in renal impairment (see Appendix B) See Section 2.4 for immunocompromised individuals (Pharmacists can consider prescribing an initial limited supply of treatment if clinically appropriate to mitigate the risk of delay in access to treatment. Treatment should be limited to the dose or time necessary for an individual to access the referral pathway.)
3rd Line Option (if 1st and 2nd line options not available or unsuitable)				
Famciclovir	125mg, 250mg or 500mg Tablets	500mg orally every 8 hours	7 Days **If immunocompromised:** 10 days and continue for 2 days after crusting of lesions.	Dose reduction in renal impairment (see Appendix B) See Section 2.4 for immunocompromised individuals (Pharmacists can consider prescribing an initial limited

				supply of treatment if clinically appropriate to mitigate the risk of delay in access to treatment. Treatment should be limited to the dose or time necessary for an individual to access the referral pathway.)

3.2 Summary of Product Characteristics including warnings, cautions, contraindications, interactions and side effects.

Visit the Health Products Regulatory Authority (HPRA) website for detailed drug information (summary of product characteristics and patient information leaflets). Dosing details, contraindications and drug interactions can also be found in the Irish Medicines Formulary (IMF) or other reference sources such as British National Formulary (BNF).

3.3 Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via HPRA Pharmacovigilance, website: www.hpra.ie

3.4 Procedure for the reporting and documentation of errors and near misses involving the medication including open disclosure.

PSI Advice on Medication Error Management:
https://www.psi.ie/practice-supports/practice-updates-and-learnings/advice-medication-error-management
PSI Open Disclosure:
Open Disclosure | PSI

3.5 Resources and equipment necessary for care under the protocol to be specified. This is dependent on the assessment requirements and best practice guidelines identified for the clinical condition.

- HSE National Consent Policy
- Chaperone Policy
- Patient Consultation Area
- Infection Prevention Control Measures
- Protecting Staff – Occupational Health

4. Patient/service-user care information

4.1 General Advice for Self-Care and Safety Netting

An individual should see their GP or other relevant Medical Practitioner if symptoms are persisting and/or deteriorating (new vesicles, worsening rash, pustular discharge, potential superinfection, non-resolution of symptoms indicating a potential alternative diagnosis) for longer than seven to ten days after rash onset.

- Individuals should:
  - Be advised they are contagious until all the vesicles have scabbed over (usually seven to ten days after rash onset). Lesions will continue to appear for up to one week, within the locality of the affected nerve. Exposed lesions should remain covered, particularly exposed areas such as the neck, when in public.
  - Ensure timely and appropriate hand hygiene. Avoid touching the affected area and wash hands with soap and water if the area has been touched.
  - Maintain adequate hydration.
  - Be advised that pain and general symptoms will subside gradually as the eruption disappears. If necessary, the individual should be advised to take simple over-the-counter (OTC) analgesia e.g. paracetamol or ibuprofen to ease the pain.
  - It can take up to four weeks for the rash to heal.
  - Wear loose-fitting clothing to reduce irritation.
  - Keep the rash clean and dry to reduce risk of bacterial infection.
  - Avoid topical creams and adhesive dressings.
  - Seek medical advice if fever develops.
  - Hold a cool compress (a bag of frozen vegetables wrapped in a towel or wet cloth) to the rash a few times a day.
- Individuals should not:
  - Let dressings or plasters stick to the rash.
  - Wear clothes that irritate the skin.
  - Use antibiotic cream – this can slow healing.
- Individuals should be advised to avoid contact with:
  - Individuals who never had chickenpox before, particularly pregnant women or those where immunity is unknown.
  - Immunocompromised individuals.
  - Babies less than 1 month old – unless it is their baby.

Vaccination
Consideration should be given to future shingles vaccination. It is only available privately. See NIAC Immunisation Guidelines Chapter 23.

4.2 Medication information to be provided to the individual/parent/legal guardian using the authorised patient information leaflet if one is available.

- Signpost to available resources on HSE A-Z and the HSE app.
- Medication Patient Information Leaflets (PILs).

Key References

- HPRA https://www.hpra.ie/
- HSE Antibiotic Prescribing https://www.hse.ie/eng/services/list/2/gp/antibiotic-prescribing/
- HSE A-Z https://www2.hse.ie/conditions/
- NIAC Immunisation Guidelines https://www.rcpi.ie/Healthcare-Leadership/NIAC/Immunisation-Guidelines-for-Ireland
- UpToDate Epidemiology, clinical manifestations, and diagnosis of herpes zoster and related images https://www.uptodate.com/contents/epidemiology-clinical-manifestations-and-diagnosis-of-herpes-zoster
- DermNet DermNetNZ.org (Images as identified)

Appendix A – Clinical Sub-Group Membership

Core Membership

- Dr. Siobhán Ní Bhriain - HSE National Clinical Director Integrated Care (Chair)
- Dr. David Hanlon - HSE National Clinical Advisor Primary Care (Vice Chair)
- Ms. Ciara Kirke - HSE Clinical Lead National Medication Safety Programme
- Ms. Linda Fitzharris - HSE PCRS Head of Pharmacy
- Dr. Diarmuid Quinlan - Medical Director ICGP & GP
- Ms. Elaine Dobell - HSE General Manager, Office of National Clinical Director Integrated Care
- Ms. Marie Philbin - AMRIC Chief Pharmacist
- Mr. Jonathon Morrissey - Community Pharmacist
- Ms. Áine McCabe - Community Pharmacist
- Dr. Clíona Murphy – National Women and Infants Health Programme
- Ms. Sarah Clarke - Medicines Management Programme

General Membership as needed

- Ms. Aoife Doyle - HSE National Clinical Lead for Ophthalmology
- Prof. Anne Marie Tobin - HSE National Clinical Lead for Dermatology
- Dr. Eavan Muldoon - HSE National Clinical Lead for Infectious Diseases
- Dr. Seán O'Dowd - HSE National Clinical Lead for National Dementia Office representing National Clinical Programme for Neurology on behalf of Prof. Sinéad Murphy
- Ms. Ruth Hoban - HSE West Assistant Director of Nursing and Midwifery for Nurse Prescribing on behalf of Dr. Geraldine Shaw
- Prof. Fiona Lyons - HSE National Clinical Lead for Sexual Health
- Ms. Caoimhe Gleeson - HSE National Office for Human Rights and Equality Policy
- Dr. Andrew Bolas - Assistant National Oral Health Lead
- Dr. Myra Herlihy - Assistant National Oral Health Lead Special Care and Training

Shingles CSG Working Group

- Dr. Eavan Muldoon - HSE National Clinical Lead for Infectious Diseases
- Dr. David Hanlon - HSE National Clinical Advisor Primary Care (Vice Chair)
- Ms. Ciara Kirke - HSE Clinical Lead National Medication Safety Programme
- Ms. Marie Philbin - AMRIC Chief Pharmacist
- Mr. Jonathon Morrissey - Community Pharmacist

Appendix B – Renal Impairment Prescribing Table Antivirals

Source: https://www.hse.ie/eng/services/list/2/gp/antibiotic-prescribing/drug-interactions/renal-impairment-prescribing-table-antiviral-170920.pdf

Renal Impairment Prescribing Table – ANTIVIRALS

Dose adjustments recommended in this table are applicable to the infections detailed on www.antibioticprescribing.ie for the treatment of community infections only. All doses are oral and for adults unless otherwise stated.

Use either eGFR or calculated CrCl figure to direct to relevant dosing column in tables below.

Drug	Stage 3A / Stage 3B	Stage 4	Stage 5
	eGFR (ml/min/1.73m^2) or calculated **CrCl** (ml/min)		
	30 - 50	**10 - 30**	**<10**
Aciclovir • 400mg every 8 hours	No adjustment required		200mg every 12 hours
• 200mg five times daily	No adjustment required	**10-25:** 200mg every 6-8 hours	200mg every 12 hours
• 800mg five times daily	No adjustment required	**10-25:** 800mg every 8 hours	800mg every 12 hours
Famciclovir • 250mg every 8 hours	**20-39:** 250mg every 12 hours	**<20:** 250mg every 24 hours	
• 1g every 12 hours for 1 day (HSV, genital, recurrent)	No adjustment required		
• 500mg every 8 hours	**40-59:** 500mg every 12 hours **20-39:** 500mg every 24 hours	**<20:** 250mg every 24 hours	
Oseltamivir • Treatment: 75mg every 12 hours	**30-60:** 30mg every 12 hours	30mg every 24 hours	30mg single dose stat
• Prophylaxis: 75mg every 24 hours	**30-60:** 30mg every 24 hours	30mg every 48 hours	30mg once, repeated after 7 days
Valaciclovir • 500mg every 12 hours	No adjustment required	500mg every 24 hours	
• 1g every 8 hours	1g every 12 hours	1g every 24 hours	500mg every 24 hours