Institution :

Collective prescription number :

Validity period :

Clinical situation or target population

**Person aged 18 years and older with one or several of the following clinical signs and symptoms:**

* Sensation of burning, discomfort or general pain in the mouth or at the corners of the mouth, which worsens when eating food.[[1]](#footnote-1)
* White patches that can be scraped away more or less easily; redness on the mucous membranes of the mouth.
* Cracked skin or slight bleeding at the corners of the mouth, which may extend to marionette lines.
* Total or partial loss of papillae on the surface of the tongue.

authorized HEALTH PROFESSIONALS OR OTHER authorized PERSONS concerned by this PRESCRIPTION [[2]](#footnote-2)

* *Health-care facilities that wish to draft collective prescriptions* *for first-line treatment of oral candidiasis in adults using this template* ***must specify in this section the health professional or group of health professionals*** *who can execute the prescription****.*** *The instruction in italics (*!*) must be deleted from the version that will be made available.*

contraindications to using this prescription

* The same contraindications as those listed for the application of Québec’s national medical protocol No. 628017, i.e.:
	+ Contraindication or history of allergic reaction to the recommended medication.
	+ Known case of refractory oral candidiasis.
	+ Oral candidiasis recurrence within one month of initial treatment.
	+ White patches that appear unilaterally on the tongue or cannot be scraped away.
	+ Bite or sore marks on the inside of the cheeks or on the tongue.
	+ Gum or submaxillary swelling.
	+ Surgery, injury, trauma, cut or burns in the mouth, or oral health problems (e.g. viral, bacterial or fungal infections) within the past two (2) weeks.
	+ Oral pain, localized or unilateral.
	+ Difficulty in swallowing, pain or burning sensation in the sternum or chest (suggesting esophageal candidiasis).
	+ Constant burning sensation that lessens when eating food (suggesting stomatopyrosis).
* Cases for whom nystatin cannot be administered.

QuÉbec’s national Medical PROTOCOL

Refer to current Québec’s national medical protocol No. 628017, written by the Institut national d’excellence en santé et en services sociaux and available on its website, when executing this prescription.

limits oR situations WHERE A consultation with an authorized prescriber IS Mandatory

* Use of collective prescription a third time in a one-year period.
* Difficulty in swallowing, pain or burning sensation in the sternum or chest during treatment (suggesting esophageal candidiasis).
* Presence or outbreak of fever during treatment.
* Aggravation of the symptoms and signs seven days after the start of the treatment.
* Persistence of the symptoms and signs at the end of the treatment.
* Allergic reaction or intolerance to prescribed antifungal.

documenting

Complete the community pharmacist liaison form, if need be. Consult the template available in the section entitled “Protocoles médicaux nationaux et ordonnances associées” on INESSS’s website.

identification of responding PrescRiber

* *Health-care facilities that wish to draft collective prescriptions for first-line treatment of oral candidiasis in adults using this template* ***must specify in this section the mechanism of identification of the responding prescriber*** *who will have to be indicated on the liaison form upon individualisation of this collective prescription. The instruction in italics (!) must be deleted from the version that will be made available.*

Implementation process

1. **Development of current version (identification of the authorized prescriber or prescribers concerned and of the persons responsible, if applicable)**
2. **VALIDATION OF THE CURRENT VERSION (identification of the authorized prescriber or prescribers concerned and of the persons responsible, if applicable)**
3. **APPROVAL OF CURRENT VERSION BY THE REPRESENTATIVE OF THE INSTITUTION’S CPDP**

Last name: First name:

Signature: Date:

1. **APPROVAL OF THE COLLECTIVE PRESCRIPTION BY THE SIGNING AUTHORIZED PRESCRIBERS (NON-INSTITUTIONAL)**

| Last and first name | License number | Signature | Telephone | Fax |
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1. **REVIEW**

Effective date :

Date of last review (if applicable) :

Scheduled date of next review :

Signature of responding prescriber (if applicable) :

Signature : Date :

1. . May present as a refusal to eat in individuals with reduced autonomy, difficulties communicating or major neurocognitive disorders. [↑](#footnote-ref-1)
2. . The authorized health professional or other authorized person must be sure to have the necessary qualifications to execute the prescription (e.g., training). [↑](#footnote-ref-2)