Integrating Clinical Pharmacists in Specialty Care

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Pharmacy Forward: Advancing Practice for a Healthier Tomorrow!

OPA Annual Conference & Trade Show April 9-11, 2026

OHIO PHARMACISTS ASSOCIATION

Disclosure Statement

- Ben Ash, Jared Malott, and Ariel Williams have no relevant financial relationship(s) with ineligible companies to disclose.

- None of the planners for this activity have relevant financial relationships with ineligible companies to disclose.

Learning Objectives

At the completion of this activity, the participant will be able to:

1. Summarize the clinical pharmacist's role in managing specialty conditions (rheumatoid arthritis, psoriasis, and multiple sclerosis) within an integrated care model
2. Illustrate how clinical pharmacists collaborate with a care team to optimize medication use, monitoring, and patient engagement in specialty care
3. Support opportunities to expand pharmacist-led interventions in chronic disease management and lifestyle modification programs to enhance clinical outcomes

Speaker Introduction

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Clinical Pharmacy Manager

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Our Mission

Improving access + outcomes for specialty care

Who We Are

Committed to our patients, our people, and our community

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Patient-First

Integrated Care

Clinical Excellence

Access & Equity

Partnership

Accountability & Outcomes

Comprehensive Disease Management (CDM)

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Melissa's treatment

Rx plan

- Skyrizi biologic medication

Supplements

- Anti-inflammatory supplement blend
- G.I. supplements

Routine testing

- Monitor inflammatory markers and low Vitamin D levels

Overall health plan

- Autoimmune nutrition program
- Improving stress responses
- Reducing grain and sugar intake
- Incorporating yoga + regular movement

AndHealth Clinical Pharmacy

Clinical Pharmacists extend the specialist reach within the organization, ensuring safety and efficacy of medications while allowing specialist to see more patients

- A Clinical Pharmacist working under a Collaborative Practice Agreement (CPA) acts as the specialist's medication-focused "right hand," independently managing drug therapy within pre-approved protocols so the specialist can concentrate on diagnosis and complex decision-making while patients get faster, safer, and more personalized care.

- The pharmacist can initiate, adjust, or discontinue medications; order and interpret labs; and document care—all within protocols approved and periodically reviewed by the specialist.

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AndHealth Clinical Pharmacy

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Complex Chronic Care

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Rheumatology: **Rheumatoid Arthritis**

Ben Ash
PharmD, BCPS, R. Ph.
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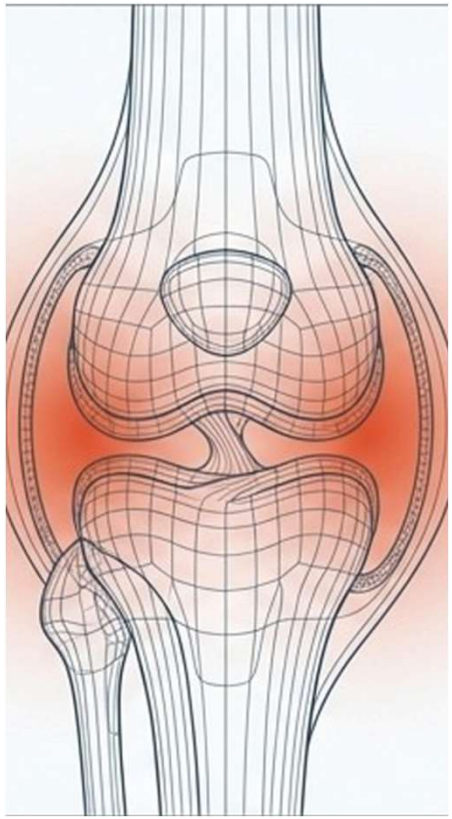


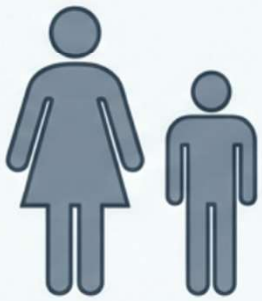
NotebookLM (Google) [2/5/2026]

Definition

A chronic, progressive, systemic autoimmune condition primarily targeting synovial joints, leading to cartilage/bony destruction and disability.

Epidemiology

- **Global Prevalence:** ~1%
- **US Prevalence:** ~0.6-1%
- **Peak Onset:** 40–70 years
- **Gender Ratio:** Women > Men



Bone research, *6*(1), 15.
Journal of clinical medicine, *10*(15), 3289.
Journal of comorbidity, *9*, 2235042X19853484.

Economic & Social Impact

19.3
Billion USD
Annual Healthcare Costs

35%
Work Disability Prevalence

3x
Indirect costs vs treatment costs

Clinical Phenotypes: Serostatus & Prognosis

Seropositive RA

Presence of RF and/or ACPA

- Most common phenotype.
- Aggressive disease trajectory.
- High risk of extra-articular manifestations.

Seronegative RA

Absence of RF and ACPA

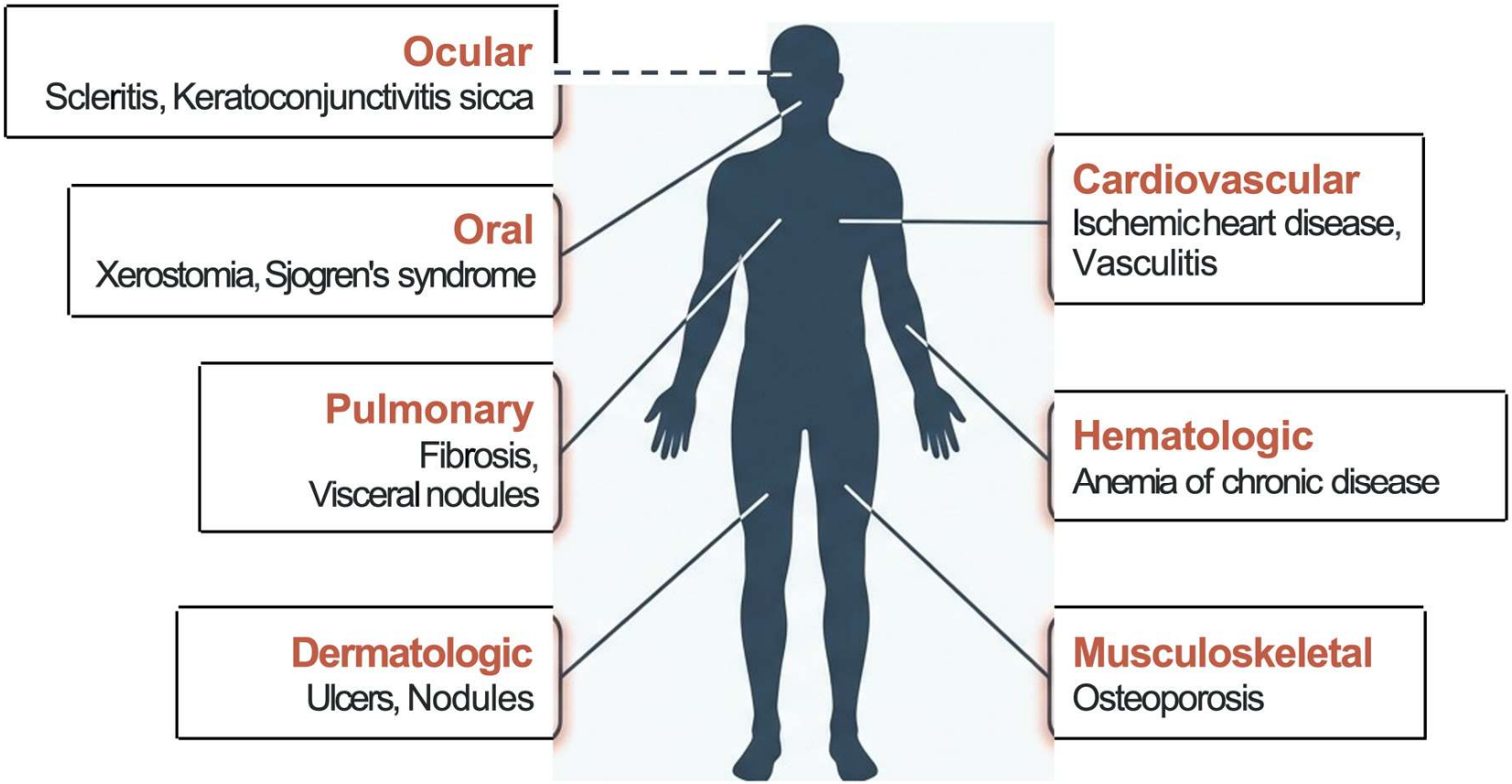
- Represents ~20–30% of patients.
- Diagnosis is clinical.
- Erosive arthritis can still occur despite negative labs.

Frontiers in Medicine, *9*, 978351.
Maedica, *5*(4), 286.

NotebookLM (Google) [2/5/2026] NotebookLM

NotebookLM (Google) [2/5/2026]

Systemic Reach: Extra-articular Manifestations



Maedica, *5*(4), 286.

Diagnosis: 2010 ACR-EULAR Classification Criteria

DIAGNOSTIC THRESHOLD: Score ≥ 6

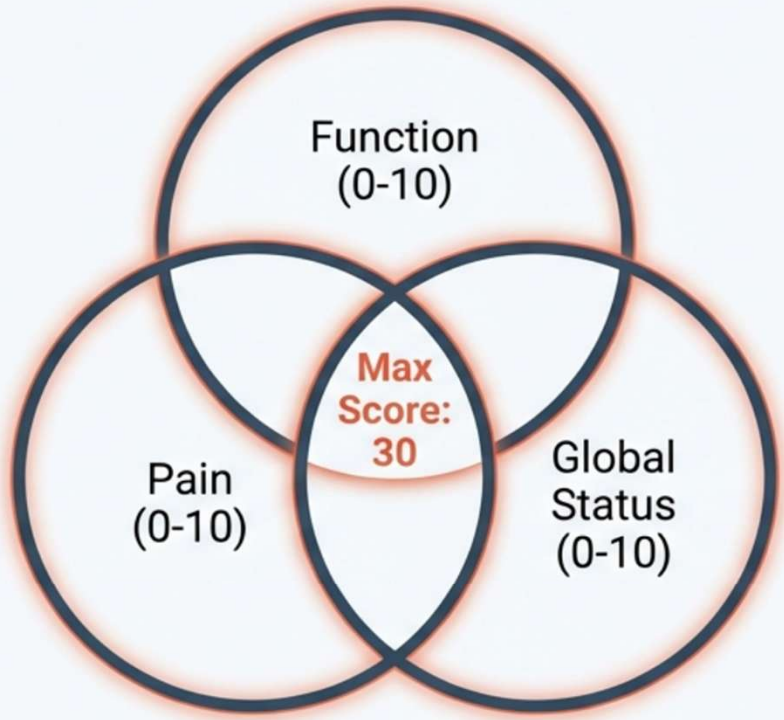
A: Joint Involvement (0-5)		B: Serology (0-3)	
☐ 1 large joint	0	☐ Negative RF & ACPA	0
☐ 2-10 large joints	1	☐ Low-positive RF or ACPA	2
☐ 1-3 small joints	2	☐ High-positiive RF or ACPA	3
☐ 4-10 small joints	3		
☐ >10 joints (at least 1 small)	5		
C: Acute-Phase Reactants (0-1)		**D: Duration (0-1)**	
☐ Normal CRP & ESR	0	☐ <6 weeks	0
☐ Abnormal CRP or ESR	1	☐ ≥6 weeks	1

Prerequisites: 1) At least 1 joint with definite clinical synovitis. 2) Synovitis not better explained by another disease.

Rheumatology, *51*(suppl_6), vi5-vi9.

Assessing Activity: RAPID-3

Routine Assessment of Patient Index Data 3



0-3: Remission

3.1-6: Low Activity

6.1-12: Moderate Activity

>12: High Activity

Pooled index of 3 patient-reported outcomes. Correlates with DAS28/CDAI.

NotebookLM

Rheumatic diseases clinics of North America, *35*(4), 773-8.

The Pharmacologic Arsenal

csDMARDs (Conventional Synthetic)	bDMARDs (Biologics)	tsDMARDs (Targeted Synthetic)
• Methotrexate (Anchor drug) • Hydroxychloroquine • Sulfasalazine • Leflunomide	**TNF Inhibitors** • Adalimumab • Etanercept • Infliximab • Golimumab • Certolizumab **T-cell Costimulation** • Abatacept **IL-6 Receptor** • Tocilizumab • Sarilumab **Anti-CD20** • Rituximab	**JAK Inhibitors** • Tofacitinib • Baricitinib • Upadacitinib

*DMARD = Disease-Modifying Antirheumatic Drug

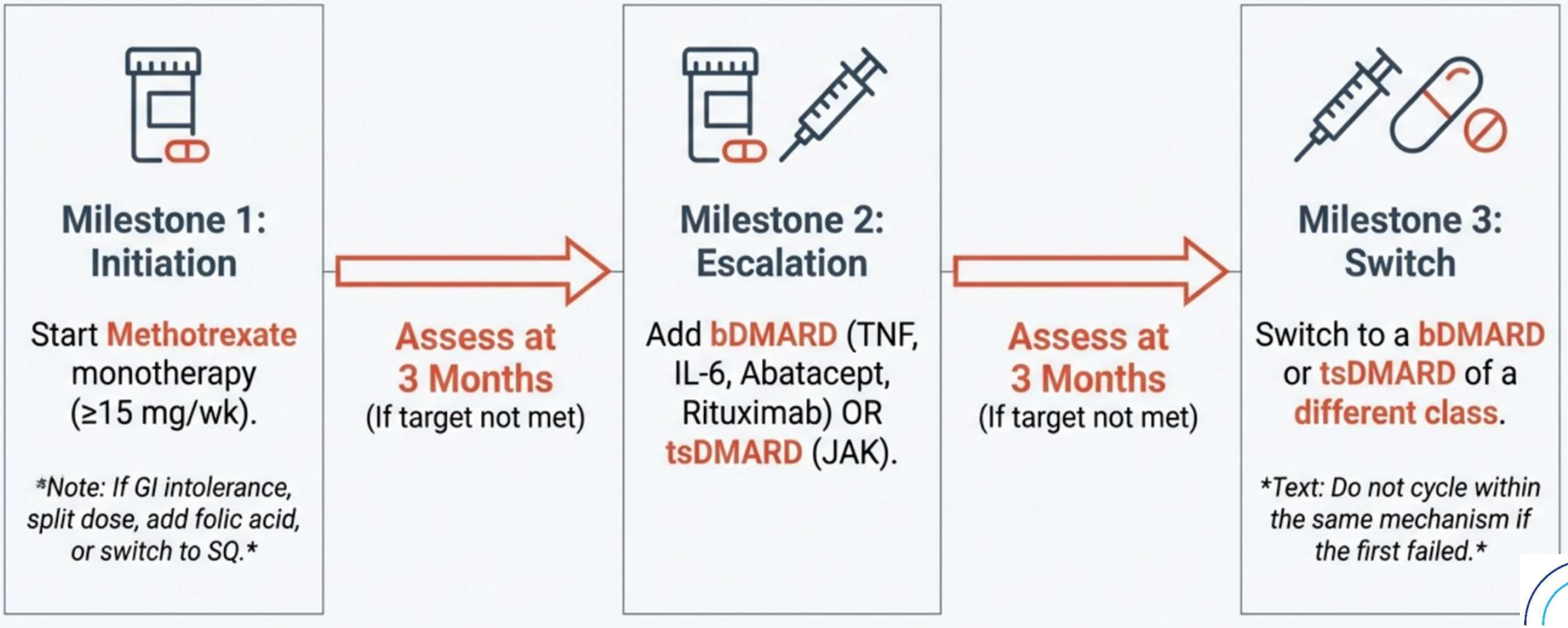
Arthritis & Rheumatology, *73*(7), 1108-1123.

NotebookLM (Google) [2/5/2026] NotebookLM

NotebookLM (Google) [2/5/2026]

ACR Treatment Algorithm (Moderate-High Activity)

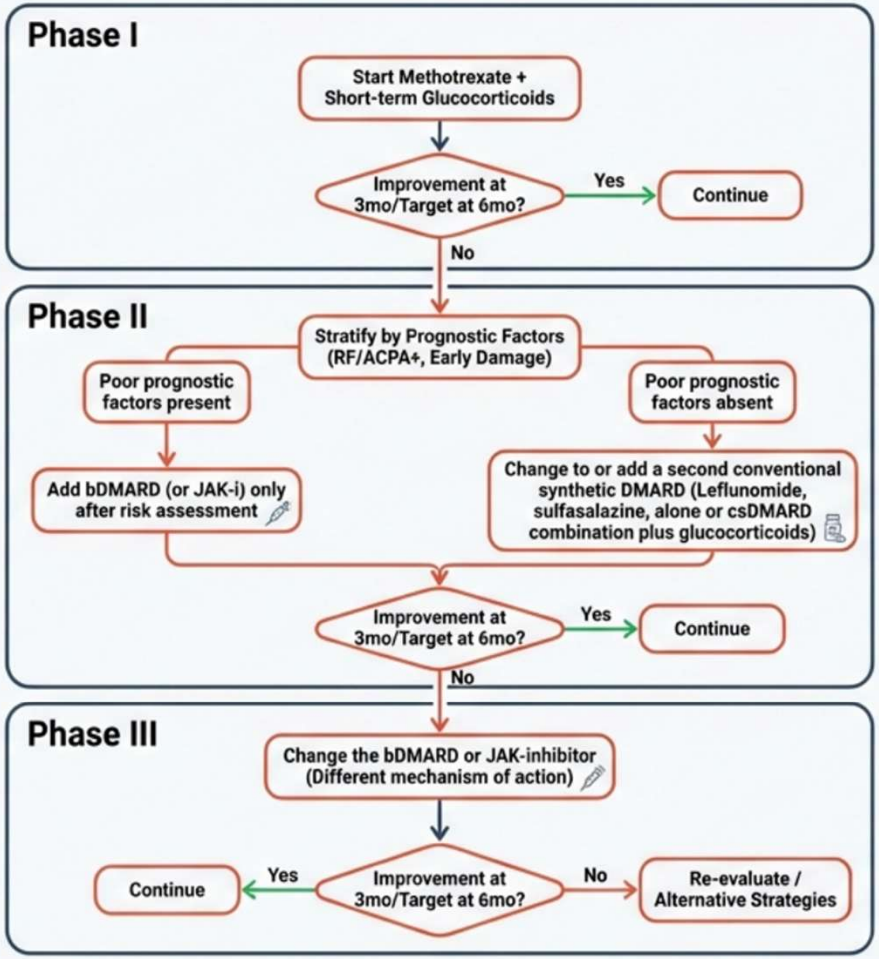
Strategy: Treat-to-Target (Low Activity or Remission)



Arthritis & Rheumatology, *73*(7), 1108-1123.

NotebookLM (Google) [2/5/2026]

EULAR Treatment Algorithm

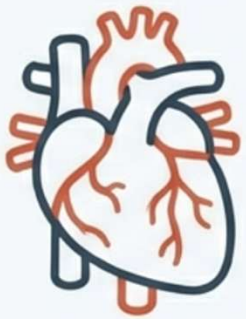


Ann Rheum Dis 2023;82:3-18

NotebookLM (Google) [2/5/2026]

Special Populations & Comorbidities

Navigating Contraindications



Heart Failure

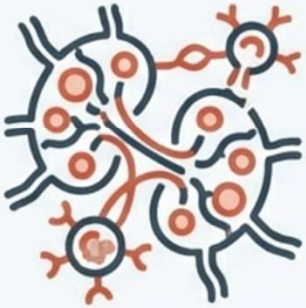
AVOID TNF Inhibitors

Worsening outcomes observed in CHF patients.

Pulmonary Disease

CONSIDER Abatacept

Methotrexate is conditionally recommended but monitor closely. Abatacept may be treatment of choice.

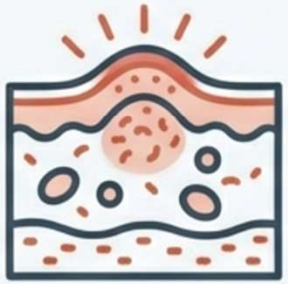


Lymphoproliferative Disorders

CONSIDER Rituximab

- **AVOID** TNF Inhibitors in Lymphoma

(Note: Overall malignancy risk not increased by TNF/Rituximab/Anakinra)



Accelerated Nodulosis

SWITCH to non-MTX DMARD

Methotrexate may induce nodulosis.

Journal of clinical medicine, *8*(12), 2038.
Archives of Rheumatology, *34*(2), 225.
Journal of Clinical Medicine, *9*(4), 1082.
Journal of Rheumatic Diseases, *29*(3), 162.

Patient Case: Rheumatoid Arthritis with Inadequate Response to Methotrexate

- **Patient Profile: 52-year-old female** presenting for follow-up of RA diagnosed 8 months ago; initially presented with symmetric polyarthritis and **morning stiffness lasting 90 minutes**.
- **Initial Clinical Picture:** High titer Rheumatoid factor and **Anti-CCP >200 units/mL**; elevated inflammatory markers (ESR 48 mm/hr, CRP 3.2 mg/dL).
- **Treatment History:** Initiated on **methotrexate (MTX) 15 mg weekly** with a prednisone taper; MTX increased to **20 mg weekly** after 3 months due to persistent symptoms.
- **Current Status (6 months post-initiation):** Reports persistent pain and swelling affecting her ability to work; examination reveals **8 tender and 6 swollen joints**.
- **Objective Data:**
  - **DAS28-CRP: 5.2** (indicating moderate to high disease activity).
  - **Imaging:** Radiographs show **early erosive changes** in the 2nd and 3rd MCP joints bilaterally.
- **Management Considerations:** Patient has **no contraindications to biologic therapy** and no history of tuberculosis, hepatitis B or C, or recurrent infections.

Patient Case: Rheumatoid Arthritis with Inadequate Response to Methotrexate

Which of the following represents the **most appropriate next step** in this patient's management?

A. Increase methotrexate to 25 mg weekly and reassess in 3 months
B. Add hydroxychloroquine to current methotrexate therapy
C. Add a biologic DMARD or targeted synthetic DMARD to methotrexate
D. Switch from oral to subcutaneous methotrexate and reassess in 3 months

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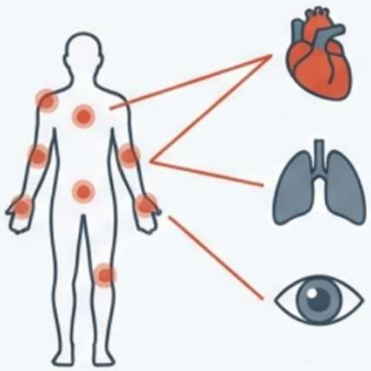
Summary & Key Takeaways

01
Systemic Burden



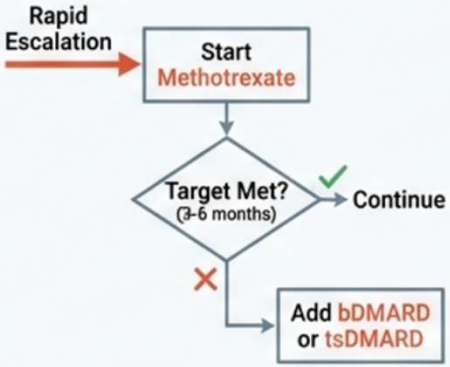
RA is a systemic, high-cost condition.

Beyond joints, it impacts cardiovascular, pulmonary, and ocular systems.

02
Definitive Diagnosis

Utilize the ACR-EULAR criteria. A score of ≥ 6 (based on joints, serology, reactants, and duration) confirms diagnosis.

03
Treat-to-Target

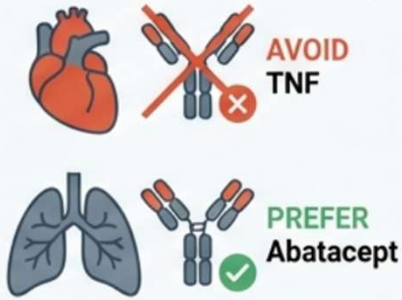


Rapid escalation is key.

Start Methotrexate. If target not met in 3-6 months, add bDMARD or tsDMARD.

04
Personalized Care

Adapt for comorbidities



Adapt for comorbidities.

Avoid TNFs in Heart Failure/Lymphoma.

Prefer Abatacept in Lung Disease.

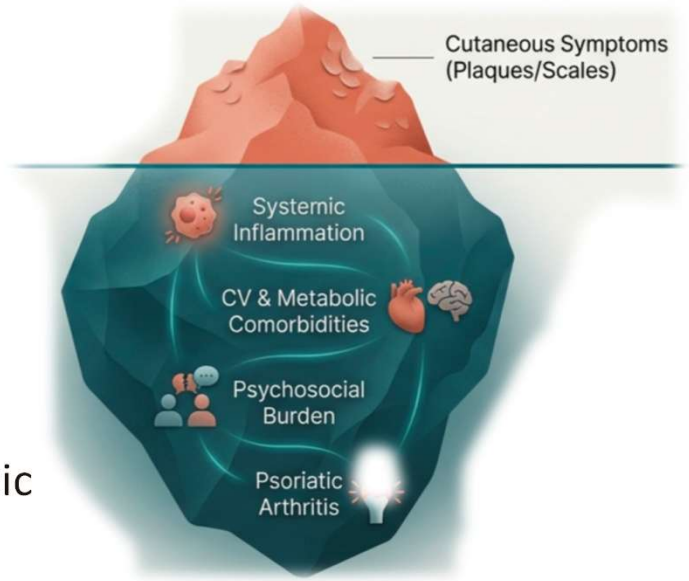
Dermatology: **Psoriasis**

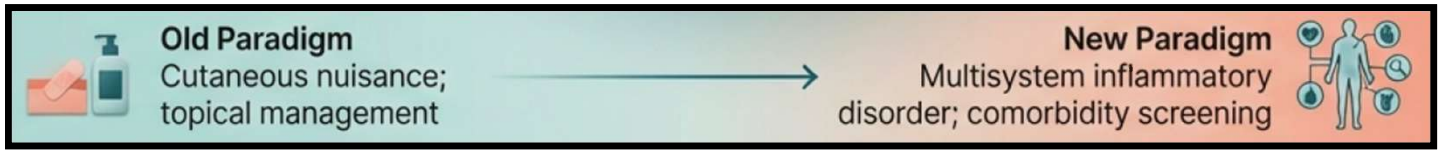
Jared Malott
PharmD, R. Ph.
Clinical Pharmacist

Psoriasis Overview: More Than Skin Deep

Psoriasis is a chronic, relapsing, systemic inflammatory disease

- **Prevalence:**
  - 7.4 Million - Approximate prevalence in the United States
  - 1.7 Million - Americans with moderate- to-severe disease
  - 59% - of moderate-to-severe patients remain untreated
- **Plaque Psoriasis** = most prevalent form
  - Characterized by erythematous, scaly, well-demarcated plaques
- A multisystem disease associated with comorbidities like psoriatic arthritis, cardiovascular disease, and metabolic syndrome





Parisi R, et al. *J Invest Dermatol.* 2013;133:377–385.
Boehncke WH, Schön MP. *Lancet.* 2015;386:983–994.
Takeshita J, et al. *J Am Acad Dermatol.* 2017;76:377–390.
NotebookLM (Google) [2/5/2026]

Types of Psoriasis

Plaque Psoriasis (80–90%)

Well-demarcated, erythematous plaques with silvery scale. Common on extensor surfaces (elbows/knees) and scalp.

Guttate Psoriasis

'Raindrop' lesions (<1cm). Acute onset, often in children/young adults following a Streptococcal infection (1-2 weeks prior).

Inverse Psoriasis

Found in skin folds (axillae, groin). Smooth, shiny red plaques with *minimal scale* due to moisture. Often misdiagnosed as fungal infection.

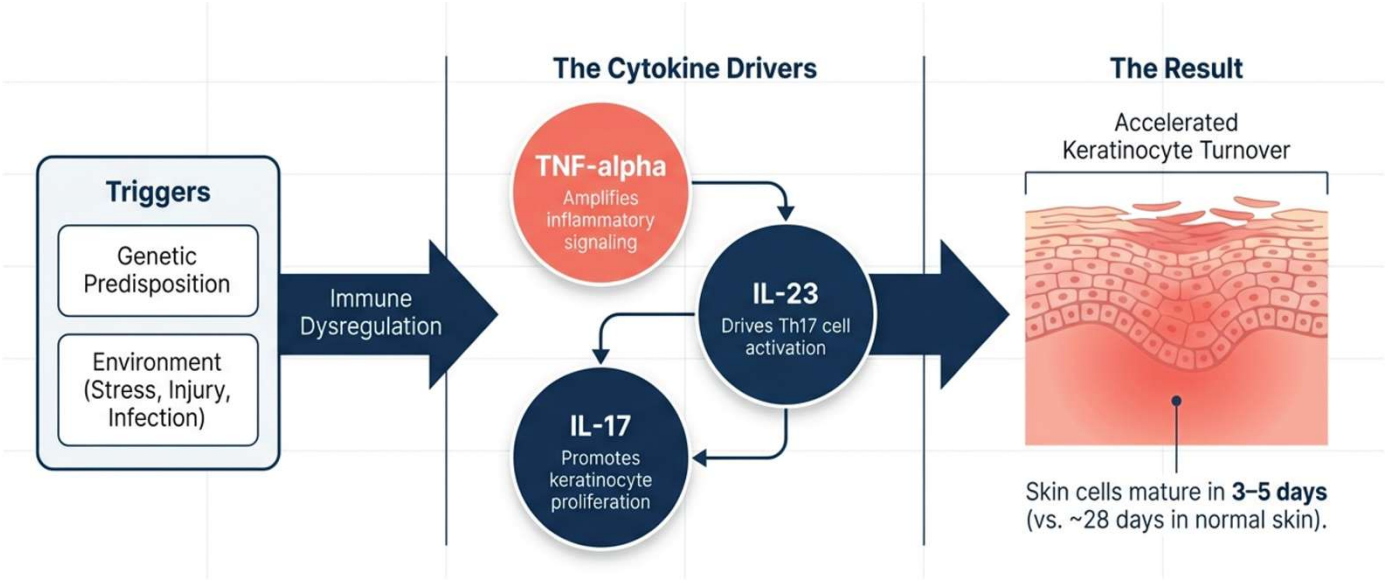
Severe Variants

Pustular Psoriasis: Sterile yellow-white pustules on erythematous base; can be localized (palms/soles) or generalized.

Erythrodermic Psoriasis: Rare medical emergency involving >75-90% BSA. Risk of thermoregulatory failure and fluid imbalance.

Elmets CA, et al. *J Am Acad Dermatol.* 2019;80:1029–1072.
Rendon A, Schäkel K. *Int J Mol Sci.* 2019;20:1475.
NotebookLM (Google) [2/5/2026]

Pathophysiology



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NotebookLM (Google) [2/5/2026]

Assessment and Severity

AAD 15 Requirement: Document Body Surface Area (BSA).

The Threshold:

BSA > 10%

Mandate: If BSA > 10%, patient must be prescribed:

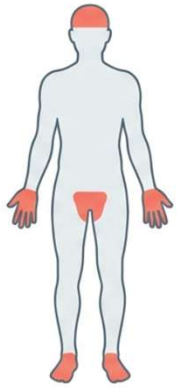
- Phototherapy
- Oral Systemic
- Biologic

The Standard Metric: BSA

One patient handprint ≈ 1% BSA

- Mild: <3%
- Moderate: 3–10%
- Severe: >10%

The "Special Areas" Exception



Special Areas Rule: Low BSA does *not* equal mild disease if these areas are involved.

Impact: High functional impairment or Quality of Life impact (DLQI score) upgrades the patient to Moderate/Severe regardless of BSA.

Pharmacist Pearl: Documentation of 'Special Site' involvement is often the missing key to overturning a Prior Authorization denial for a patient with low BSA.

Parisi R, et al. *J Invest Dermatol.* 2013;133:377–385.
Boehncke WH, Schön MP. *Lancet.* 2015;386:983–994.
Takeshita J, et al. *J Am Acad Dermatol.* 2017;76:377–390.
NotebookLM (Google) [2/5/2026]

Severity-Driven Treatment

Guided by:

- disease severity
- anatomic involvement
- comorbidities
- patient-specific factors

Treatment Goals:

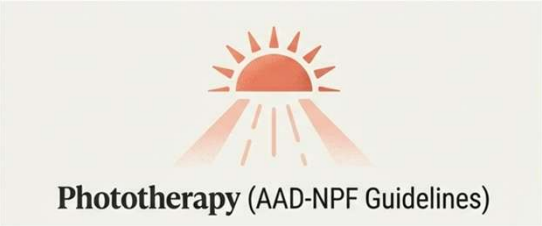
- Skin clearance
- Durable disease control
- Symptom relief
- Improved quality of life

Menter A, et al. *J Am Acad Dermatol.* 2019;80:1029–1072.
Menter A, et al. *J Am Acad Dermatol.* 2020;82:1445–1486.
NotebookLM (Google) [2/5/2026]

Treatment: Mild to Moderate Disease

- **First-Line (Topicals):**
  - **Corticosteroids**
  - **Vitamin D Analogs**
  - **Combination**
  - **Other Agents**

- **Phototherapy:**
  - Considered for patients with >3% BSA or localized refractory disease.
  - **Narrowband UVB (NB-UVB):** The preferred first-line phototherapy (Grade A recommendation) due to safety and efficacy.



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Takeshita J, et al. *J Am Acad Dermatol.* 2017;76:377–390.
NotebookLM (Google) [2/5/2026]

Treatment: Moderate to Severe (Systemic Non-Biologics)

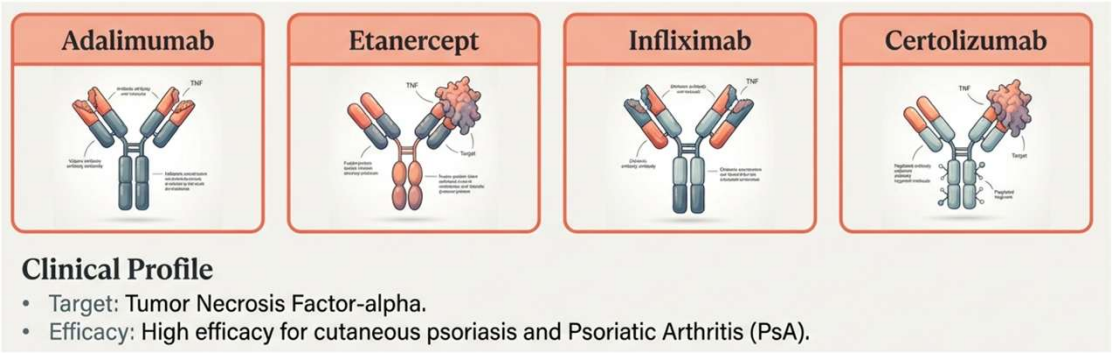
Indication: For patients with BSA >3% or those who fail topicals or phototherapy.

Agent	Indication	Monitoring Required
Methotrexate	Mod-to-severe disease	Hepatotoxicity (Liver enzymes/Fibrosis) Renal function
Less effective than Adalimumab/Infliximab for skin.		
Cyclosporine	Severe, recalcitrant, or erythrodermic	Nephrotoxicity (Kidney function) Hypertension (BP)
Rapid relief, intermittent use.		
Acitretin	Monotherapy or w/ PUVA/UVB	Lipids Liver enzymes
Teratogenic. Strictly contraindicated in pregnancy.		
Apremilast	Mod-to-severe disease	Renal monitoring
Associated with weight loss.		

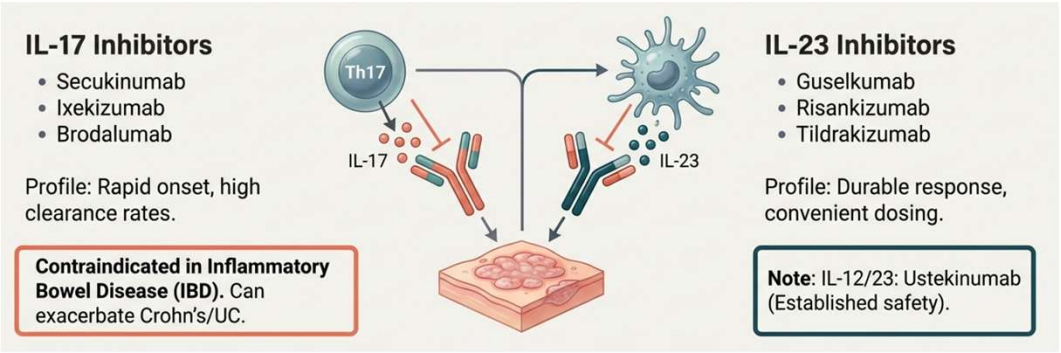
Parisi R, et al. *J Invest Dermatol.* 2013;133:377–385.
Boehncke WH, Schön MP. *Lancet.* 2015;386:983–994.
Takeshita J, et al. *J Am Acad Dermatol.* 2017;76:377–390.
NotebookLM (Google) [2/5/2026]

Treatment: Moderate to Severe (Focus on Biologics)

Biologics are prescribed for patients with BSA >3% or those unresponsive to other therapies (orals/topicals).



CRITICAL CONTRAINDICATION: Avoid in Inflammatory Bowel Disease (IBD). IL-17 inhibition can exacerbate Crohn's Disease and Ulcerative Colitis.



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Takeshita J, et al. *J Am Acad Dermatol.* 2017;76:377–390.
NotebookLM (Google) [2/5/2026]

Biologic Selection and Considerations

The Hurdle: Prior Authorization

Most payers require documentation of "Step Therapy" (failure of topicals + ≥1 oral systemic) and defined severity metrics.

Common Denials & Solutions

- **Problem**: Missing severity metrics.
  → **Solution:** Consolidate metrics (calculate PGA x BSA).
- **Problem**: Low BSA denial.
  → **Solution:** Document 'Special Site' involvement to justify severity.
- **Problem**: Step therapy requirement.
  → **Solution:** Document intolerance (e.g., 'GI upset with Apremilast').

Parisi R, et al. *J Invest Dermatol.* 2013;133:377–385.
Boehncke WH, Schön MP. *Lancet.* 2015;386:983–994.
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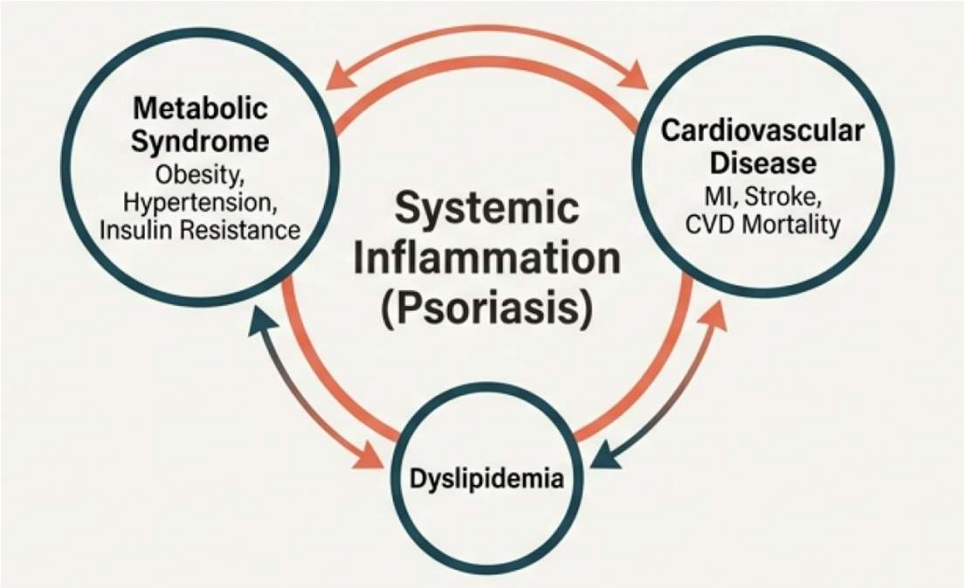
NotebookLM (Google) [2/5/2026]

"Treating the skin heals the mind"



Beyond the Heart: Mental Health, Gut, and Kidney

Mental Health & QoL

Burden: Higher rates of depression, anxiety, suicidal ideation.

Action: Screen for mood disorders.

Evidence: Biologics (Etanercept, Adalimumab, Ustekinumab) improve depression/QoL scores.

Inflammatory Bowel Disease

Link: Crohn's and UC more common.

Caution: Avoid IL-17 inhibitors.

Pearl: TNF inhibitors may treat both.

Renal Disease

Link: CKD risk correlates with BSA severity.

Action: Monitor renal function (esp. with Cyclosporine/Methotrexate).

Parisi R, et al. *J Invest Dermatol.* 2013;133:377–385.
Boehncke WH, Schön MP. *Lancet.* 2015;386:983–994.
Takeshita J, et al. *J Am Acad Dermatol.* 2017;76:377–390.
NotebookLM (Google) [2/5/2026]

Non-Pharmacologic and Lifestyle Management

Trigger Avoidance

- infections (strep), stress, skin trauma, and smoking

Weight Management

Substance Use

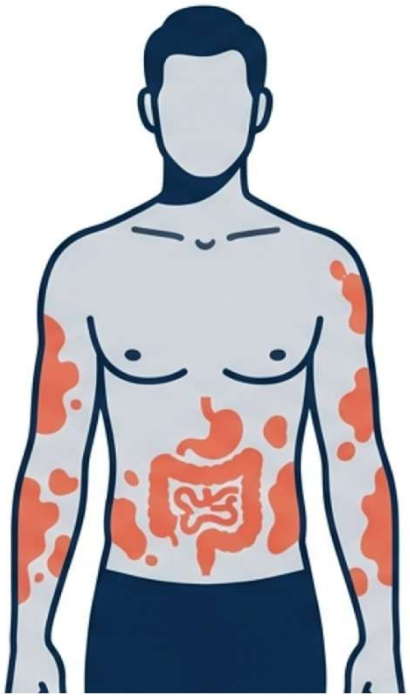
- Smoking Cessation
- Limited Alcohol Use

Mental Health

- Screen for anxiety and depression

Parisi R, et al. *J Invest Dermatol.* 2013;133:377–385.
Boehncke WH, Schön MP. *Lancet.* 2015;386:983–994.
Takeshita J, et al. *J Am Acad Dermatol.* 2017;76:377–390.

Patient Case

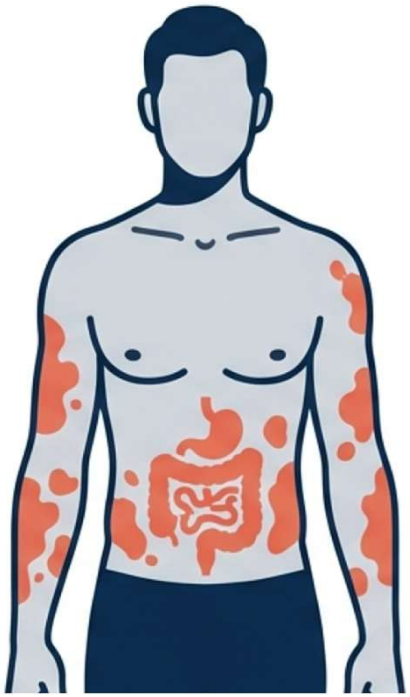


AH is a 45-year-old male presenting to the pharmacy to pick up a refill for his blood pressure medication. He mentions his psoriasis is "flaring out of control" and covering his arms, legs, and trunk.

- **History:** Plaque psoriasis for 10 years; Crohn’s Disease, HTN.
- **Current Psoriasis Meds:**
  - Clobetasol ointment (topical steroid)
  - Calcipotriene (Vitamin D analog)
  - He says these "stopped working months ago."
- **Physical Assessment:** Documented BSA is 15%, DLQI is 18.
- **Status:** The dermatologist has decided it is time to escalate to a biologic agent.

Parisi R, et al. *J Invest Dermatol.* 2013;133:377–385.
Boehncke WH, Schön MP. *Lancet.* 2015;386:983–994.
Takeshita J, et al. *J Am Acad Dermatol.* 2017;76:377–390.
NotebookLM (Google) [2/5/2026]

Clinical Decision-Making Question



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A. Tumor Necrosis Factor (TNF) inhibitors (e.g., Adalimumab)

B. Interleukin-23 (IL-23) inhibitors (e.g., Guselkumab)

C. Interleukin-17 (IL-17) inhibitors (e.g., Secukinumab)

D. IL-12/23 inhibitors (e.g., Ustekinumab)

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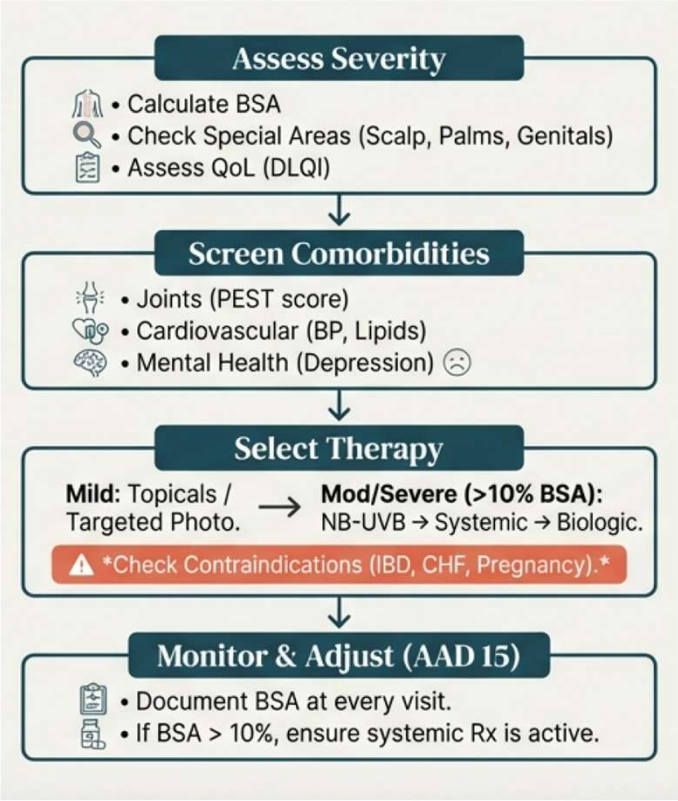

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NotebookLM (Google) [2/5/2026]

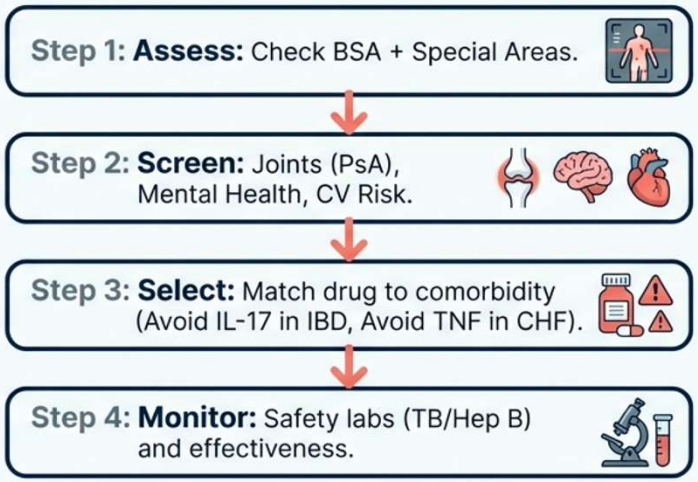
Psoriasis Key Takeaways

Summary: The Comprehensive Care Checklist

Treat-to-Target Goals:

- **BSA** ≤ 1% (Clear/Almost Clear)
- **PASI 90** response
- **DLQI ≤ 1** (No effect on quality of life)

The Pharmacist's Loop:



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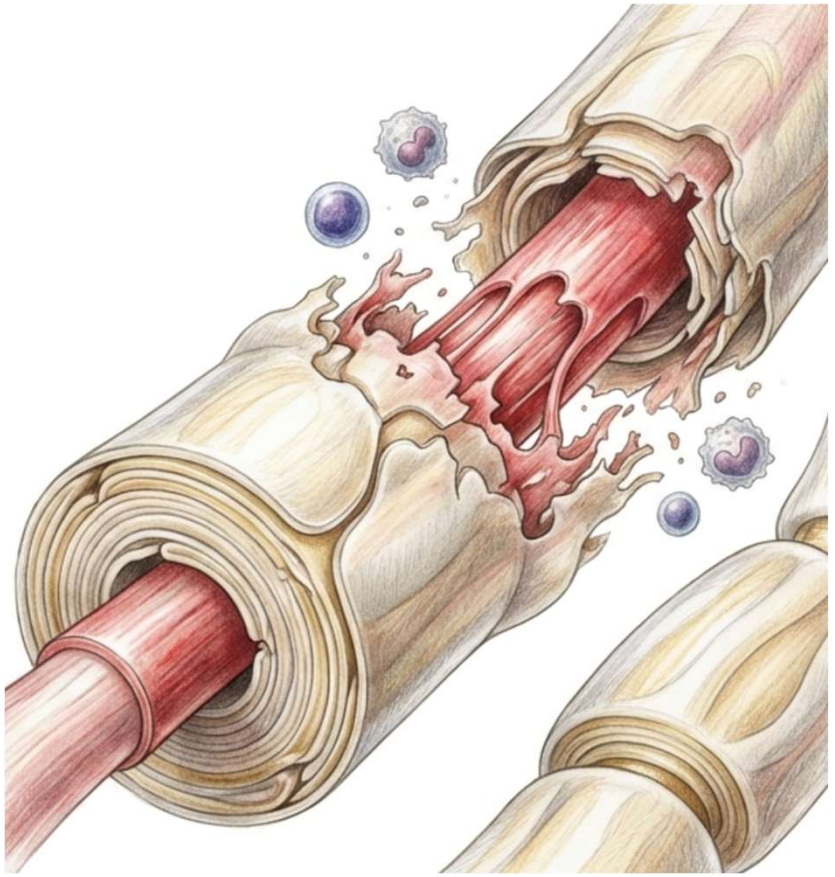
Neurology:
Multiple Sclerosis

Ariel Williams
PharmD, BCACP, R. Ph.
Clinical Pharmacy Manager



A Tale of Two Patients: The Impact of Early Intervention

Patient A (24yo)

Presentation: Optic Neuritis.

↓

Action: Treated with steroids only. Delayed DMT.

↓

Relapse *(6 weeks later)*: Permanent **blindness** & **paraparesis**.

↓

Outcome: Active MRI Lesions. PLEX initiated too late.

Patient B (21yo)

Presentation: *Ascending paresthesia & weakness.*

↓

Action: *Immediate MRI + Steroids + Rapid escalation to DMT* (Gilenya).

↓

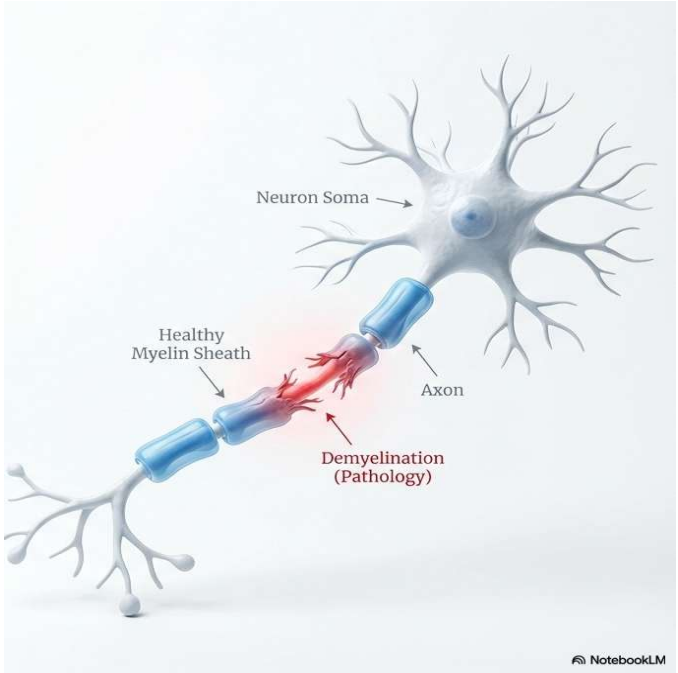
Outcome: *Near complete recovery.*

Multiple Sclerosis

Multiple Sclerosis

- Chronic, autoimmune, inflammatory disease of the central nervous system (CNS)

- Involves the destruction of myelin, which disrupts the transmission of nerve signals, leading to a wide range of neurological symptoms.



Bainbridge J, Miravalle A, Wong PS, Makelky MJ. Multiple sclerosis. In: DiPiro JT, Yee GC, Posey L, Haines ST, Nolin TD, Ellingrod V, eds. 11th ed. McGraw-Hill; 2019.
NotebookLM (Google), [02/06/2026].

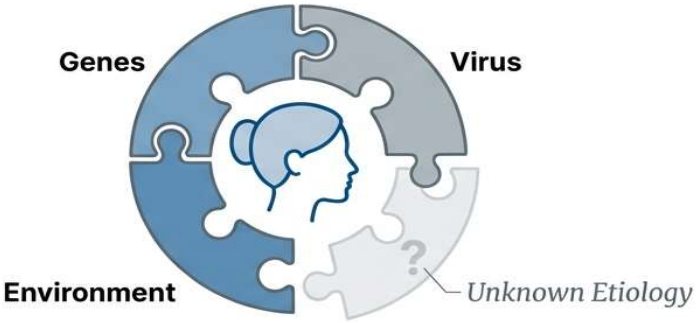
Multiple Sclerosis Overview

The Burden of Disease

- Prevalence: ~400,000 in United States
- Regional Focus: >55,000 cases in Ohio & Indiana
- Demographics: Predominantly Caucasian women
- Onset: 20-40 years of age

The Multifactorial Origin

- The exact cause remains elusive, but evidence suggests a convergence of factors:
  - Genetics
  - Environmental Factors
  - Infections
  - Immunologic Factors



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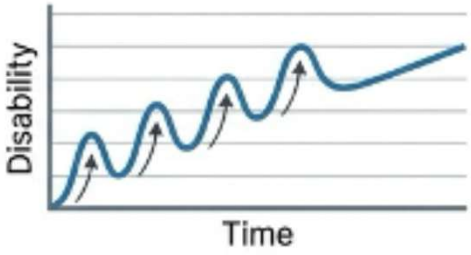
Multiple Sclerosis Phenotypes

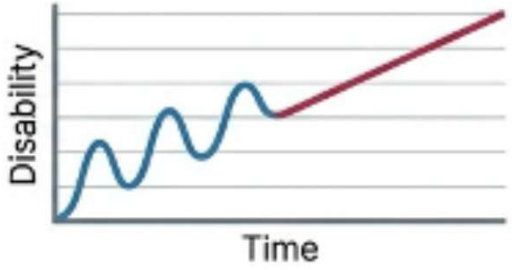
RRMS: Relapsing-Remitting
(Distinct attacks, partial recovery)



Most common

Characterized by periods of new or worsening symptoms (*relapses*) followed by periods of partial or complete recovery (*remissions*)

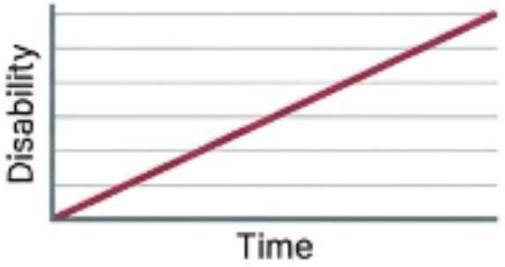
SPMS: Secondary Progressive
(Gradual worsening following RRMS)



Follows an initial RRMS episode

Steady progression of disability, with or without occasional relapses

PPMS: Primary Progressive
(Progression from onset)



Steady, gradual worsening of neurological function from the onset of symptoms, without distinct relapses or remissions

Klotz et al., *Ther Adv Neurol Disord*. 2019.
NotebookLM (Google), [02/06/2026].

Multiple Sclerosis Clinical Presentation

Optic Neuritis
(Vision loss/Pain)

Transverse Myelitis
(Paralysis/Sensory)

Brainstem
(Vertigo/Diplopia)

General
(Fatigue/Cognition)

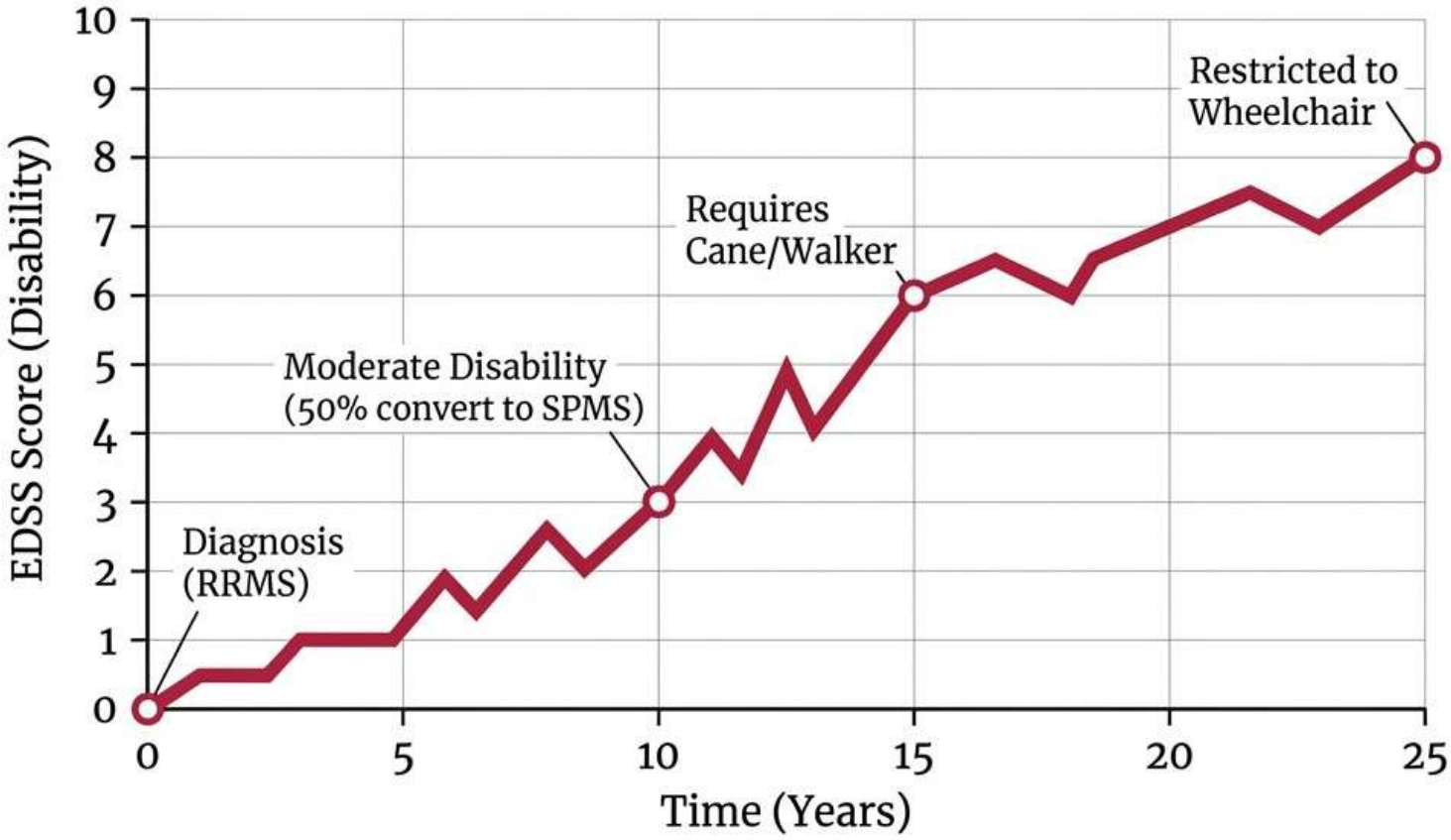
True vs. Pseudo Relapse?

True Relapse:
- New neurologic symptom lasting ≥24 hours
- Absence of infection or fever
- Involved active inflammation of myelin

Pseudo Relapse:
- Temporary worsening triggered by heat, stress, or infection
- No steroids needed
- Treat underlying cause

NotebookLM (Google), [02/06/2026].
UpToDate. (2026). Multiple sclerosis in adults. Retrieved January 16, 2026, from UpToDate.

The Cost of Inaction: “Time is Brain”



Progression without Treatment:

0.8–1.0 relapses per year.

Life expectancy reduced by 7–14 *years.*

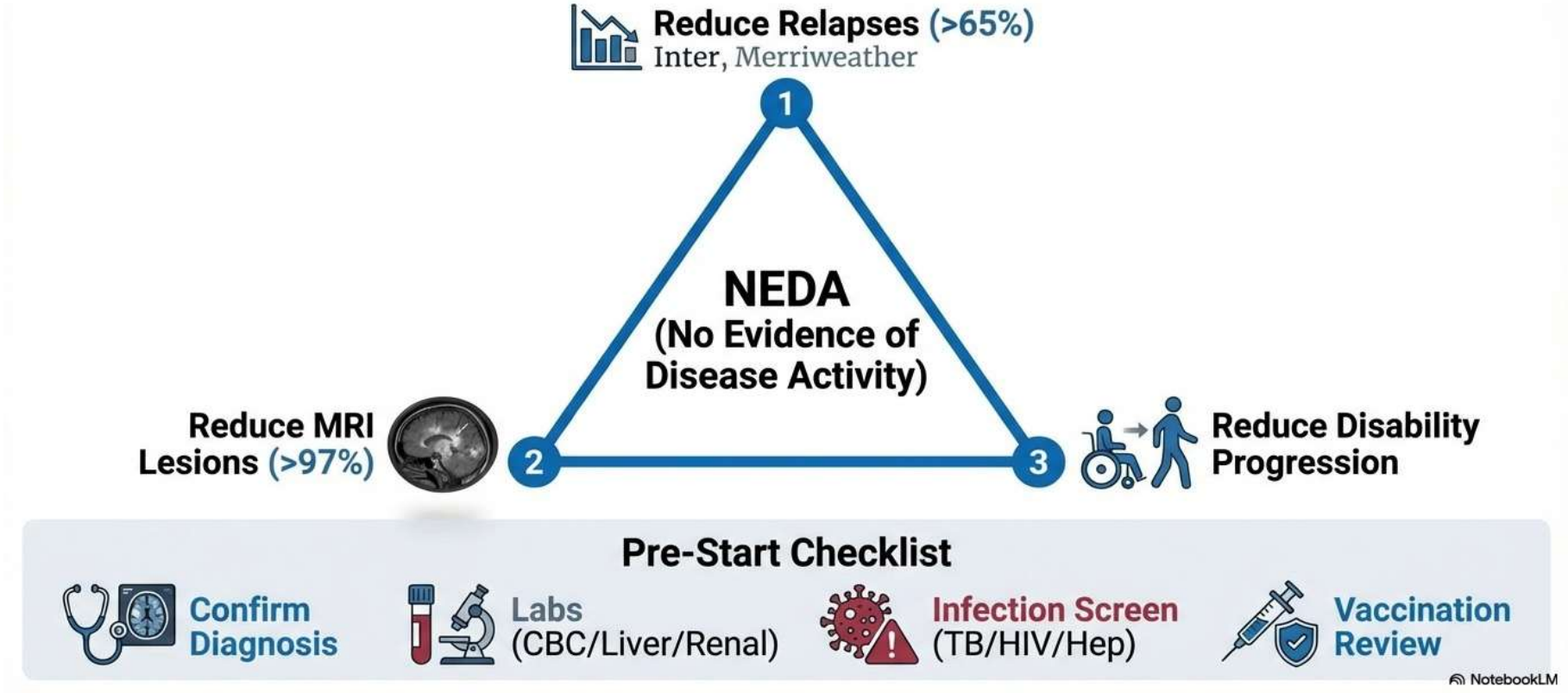
Significant impact on quality of life: fatigue, cognition, gait.

NotebookLM (Google), [02/06/2026].

NotebookLM

Multiple Sclerosis Treatment Goals

The "Trifecta"



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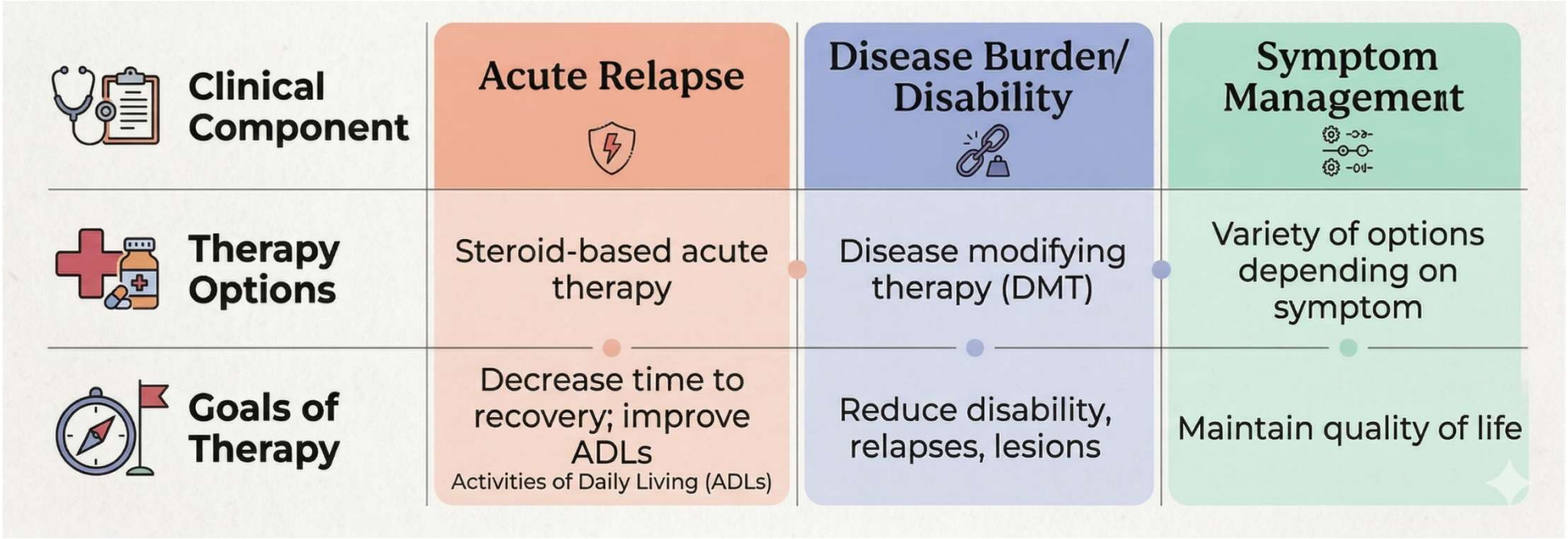
Multiple Sclerosis Treatment Considerations



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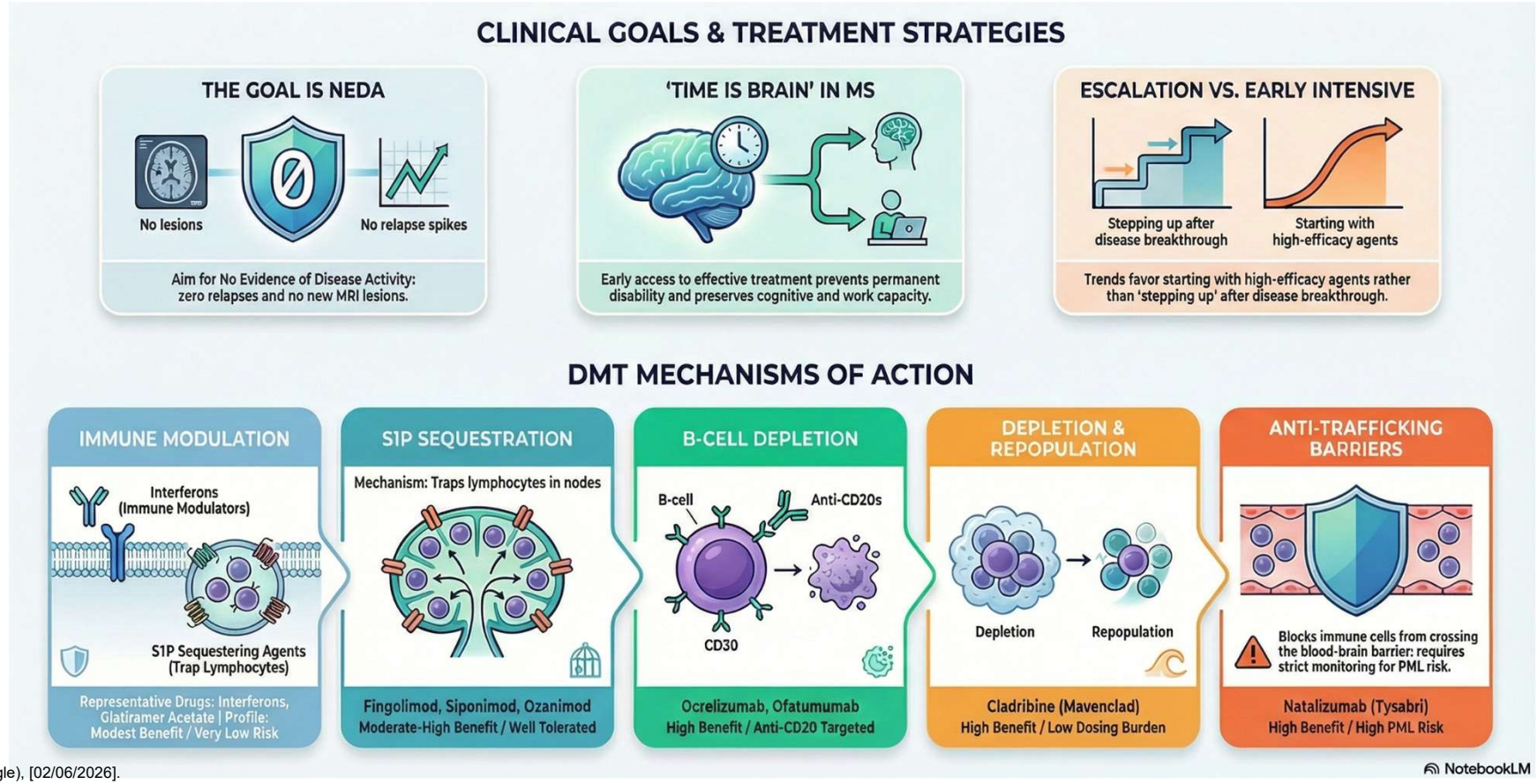
Disease-Modifying Therapies (DMTs)



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Multiple Sclerosis: Symptomatic Management

Gait Improvement

- Dalfampridine (The Walking Pill)

****Note: Contraindicated in seizure history.**

Spasticity

- Baclofen, Tizanidine

Fatigue

- Amantadine, Modafinil

Pain

- Gabapentinoids, SNRIs

NotebookLM (Google), [02/06/2026].
Rae-Grant, Alexander et al. “Practice guideline recommendations summary: Disease-modifying therapies for adults with multiple sclerosis: Report of the Guideline Development, Dissemination, and Implementation Subcommittee of the American Academy of Neurology.” *Neurology* vol. 90,17 (2018): 777-788. doi:10.1212/WNL.0000000000005347

Key Safety & Monitoring Considerations for Multiple Sclerosis

Drug Interactions:

Patients with MS frequently have complex medication regimens due to comorbidities, making polypharmacy a significant concern.

Clinicians must actively monitor for drug interactions.

Vaccinations:

Many DMTs are immunosuppressive, so vaccination status is critical.

Advise patients to receive live vaccines *before* starting therapy or to use inactivated vaccines while on treatment.

Lab Monitoring:

Baseline Screening: Conduct a pre-start checklist including a CBC, LFTs, and screens for latent infections like TB, HIV, and Hepatitis B and C.

Routine Monitoring: Many DMTs require ongoing monitoring to detect adverse effects early.

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Multiple Sclerosis Patient Case

AH is a 21-year-old female presents with a chief complain of "ascending paresthesia" (abnormal sensation) rising to her chest and weakness in her left leg.

Symptom onset was acute, prompting a neurological evaluation.

Diagnostic Workup:

• **MRI Findings:** The scan reveals 3 active lesions in the brain and 1 active lesion in the cervical spine.

Acute Phase Treatment:

• Immediate Intravenous (IV) Steroids to manage the relapse.

First-Line Disease Modifying Therapy (DMT):

• **Drug:** Interferon SQ (Subcutaneous Injection).
• **Mechanism:** Immunomodulation.
• **Class Characteristics:** Moderate benefit, very low risk profile.

The Challenge:

• Patient experienced **poor tolerability**.

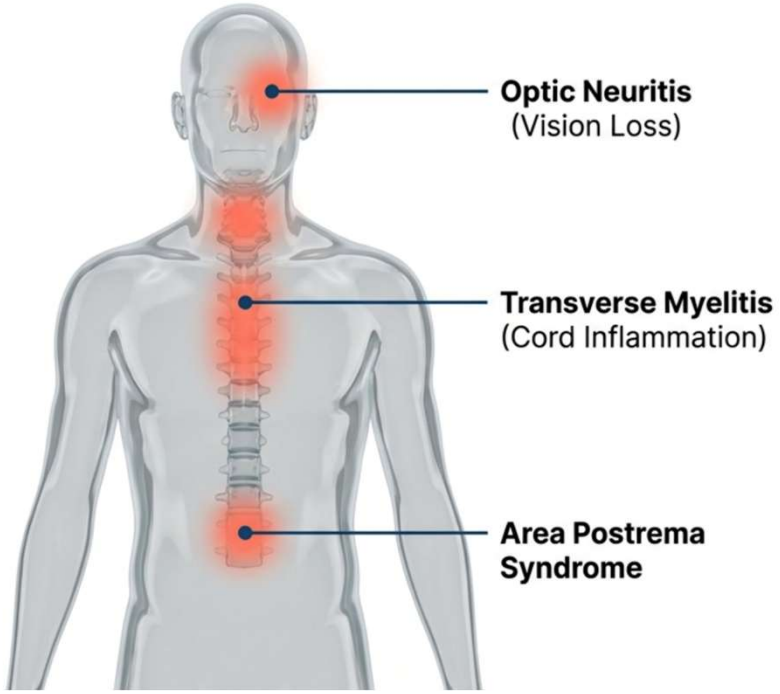
Multiple Sclerosis Patient Case

Remember: Time is brain!

- Goal: Find the right DMT for the right patient at the right time

Second-Line Therapy:

- **Drug:** Gilenya (fingolimod).
- **Route:** Oral (PO).
- **Mechanism:** S1P Receptor Modulation ("Sequestration").



Multiple Sclerosis Patient Case Question

Your patient is switching from Interferon to Gilenya (fingolimod). As the pharmacist, you review the "Pre-Start Checklist" for S1P inhibitors. Which of the following is **TRUE** regarding clinical requirements?

A. The patient requires annual MRI monitoring, but pregnancy is generally safe during therapy.
B. This medication is a "B-cell depleter," and the patient must be screened for high malignancy risk.
C. You must verify a negative pregnancy test and counsel that pregnancy is not permitted; baseline labs (CMP, Hep B/C) are required.
D. The drug functions via "Anti-trafficking" and requires serial JC Virus (JCV) monitoring every 3–6 months.

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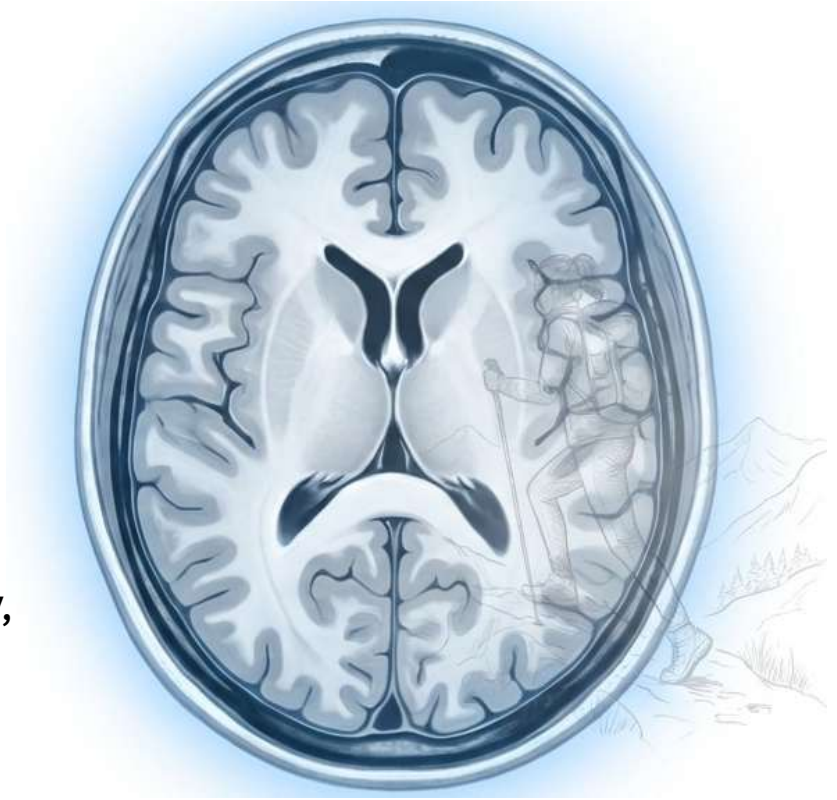
Multiple Sclerosis Key Takeaways

- Early and effective intervention is critical to preserve neurological function.
- Utilizing high effective DMTs early is vital to aggressively prevent disease progression.
- DMTs modify long-term disease progression but do not relieve daily symptoms; pharmacists must actively assist with optimizing separate, targeted medications to manage issues like fatigue, spasticity, pain, and gait impairment to maintain the patient's overall quality of life.
- Pharmacist play a vital role in ensuring baseline and routine lab monitoring to is complete and verifying patients' vaccination status.



Time is brain!

Integrating Clinical Pharmacists in Specialty Care Conclusions

- Clinical pharmacists using Collaborative Practice Agreements extend specialist reach by independently initiating and adjusting medications to ensure faster, safer patient care.
- Rheumatoid Arthritis management relies on a "treat-to-target" strategy that prioritizes rapid escalation to biologics if goals are not met, preventing irreversible joint damage.
- Psoriasis requires severity-driven care that treats the condition as a multisystem inflammatory disorder while screening for comorbidities like psoriatic arthritis and depression.
- Early intervention with Disease-Modifying Therapies is critical in Multiple Sclerosis to achieve "No Evidence of Disease Activity" and delay disability progression.
- Pharmacists play a pivotal role in ensuring medication safety through monitoring and navigating access barriers such as prior authorizations to prevent treatment delays.

Care Team Question

A clinical pharmacist is integrated into a specialty care team under a Collaborative Practice Agreement (CPA). According to the integrated care model described, which of the following best characterizes the pharmacist's scope of practice and collaboration with the specialist to optimize patient care?

A. The pharmacist focuses solely on insurance prior authorizations and does not make clinical decisions regarding patient therapy.
B. The pharmacist acts as the specialist's medication-focused "right hand," independently initiating, adjusting, or discontinuing drug therapy within pre-approved protocols to allow the specialist to focus on complex decision-making.
C. The pharmacist must receive verbal approval from the specialist for every individual lab order or medication adjustment before it is processed.
D. The pharmacist's role is limited to non-clinical patient engagement, such as scheduling appointments and verifying contact information.

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RPH Led Interventions Question

When expanding pharmacist-led interventions for patients with moderate-to-severe psoriasis, which of the following lifestyle modifications and holistic health screenings should be prioritized to enhance clinical outcomes and biologic efficacy?

A. Advising the patient to discontinue all physical activity to prevent joint aggravation.
B. Screening for mental health conditions such as anxiety and depression, and counseling on weight management, as weight loss can improve the efficacy of biologic medications.
C. Informing the patient that smoking cessation is unnecessary because nicotine does not interact with psoriasis medications.
D. Focusing exclusively on topical medication adherence without addressing systemic comorbidities like metabolic syndrome.

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More Information?

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