Derbyshire Medicines Management, Prescribing and Guidelines
Derbyshire Primary Care Formulary

Chapter 13: DRUGS ACTING ON THE SKIN
Updated: November 2017

The following prescribing guideline is relevant to the skin chapter and can be found here

- Actinic Keratosis
- Emollient Prescribing Guide
- Topical tacrolimus guidance

Specials

Specials are individually prepared formulations of existing drugs, made for a specific patient. They are usually considerably more expensive than standard preparations and are likely to incur additional prescribing costs e.g. out of pocket expenses. Creams/ointments not listed in the BNF will usually fall under the specials umbrella. It is advisable to follow these key principles:

1. Establish clinical need, is there a licensed alternative?
2. Different suppliers of the same special may have a different formulation, stability and potentially bioavailability.
3. Share the decision making process with the patient.
4. Ensure regular review for ongoing need.
5. Consider issuing acute instead of repeat prescriptions to assess patient response.
6. Expiry date of products is likely to be short.
7. BNF states that diluted creams should normally be used within 2 weeks of preparation.
8. Consider prescribing a weaker propriety steroid rather than diluting more potent steroid.
9. Consider prescribing a trial of urea cream rather than a special cream containing salicylic acid e.g. instead of 10% salicylic acid cream consider 10% urea cream (Aquadrate or Hydromol intensive), instead of 25% salicylic cream consider 25% urea cream (Flexitol Heel balm).

British Association of Dermatologist (BAD) is a charity that works closely with the Department of Health to advise the best practice and the provision of Dermatology services. It has produced a specials list to help to address concerns about high cost and lack of standards on unlicensed creams and ointments used for common dermatological conditions.

13.1 Management of skin conditions

13.1.2 Suitable quantities for prescribing for an adult

	Lotions Twice daily application for 1 week for adults	**Creams & Ointments** Twice daily application for 1 week for adults	**Corticosteroids** Once daily application for 2 weeks for adults
Face	**100 ml**	**15 to 30g**	**15 to 30g**
Both Hands	**200 ml**	**25 to 50g**	**15 to 30g**
Scalp	**200 ml**	**50 to 100g**	**15 to 30g**
Both arms	**200 ml**	**100 to 200g**	**30 to 60g**
Both legs	**200 ml**	**100 to 200g**	**100g**
Trunk	**500 ml**	**400g**	**100g**
Groins and genitalia	**100 ml**	**15 to 25g**	**15 to 30g**

13.2 Emollient and barrier preparations

See NICE clinical guidance CG57 - Management of atopic eczema in children.

13.2.1 Emollients

For treatments of minor conditions such as contact dermatitis and mild dry skin/sunburn, self-care is encouraged. *See Emollient Prescribing Guide*

Emollient choice for an individual patient involves consideration of patient preference, consistency required, patient's lifestyle and cost. There is some evidence to suggest that emollients may reduce the need to use topical steroids.

13.2.1.1 Emollient bath additives

All Shower and bath emollients have been classified as **BLACK** by JAPC and are not recommended for prescribing due to the lack of evidence of efficacy. Note: Drug and Therapeutics Bulletin (DTB: Vol. 45 No. 10 – October 2007) questioned the benefit of bath emollients. There are no published randomised controlled trials on bath emollients in atopic eczema, there is no consensus of clinical opinion that such therapy is effective. All of the emollients included in the formulary can be used as a soap substitute. The majority of bath oils and emollients can make objects very slippery, therefore caution must be taken when getting in and out of the bath, especially when caring for vulnerable groups such as older people or when handling babies.

The use of aqueous cream as a leave on emollient has the potential to damage skin with increasing evidence for sodium lauryl sulphate as the causative ingredient. Aqueous cream is not particularly effective as an emollient because of its low lipid content.[1]

13.2.2 Barrier preparations

Barrier preparations are no substitute for adequate nursing care and should not be used in isolation.
See **Derbyshire Wound Care formulary**

Conotrane cream (dimeticone, benzalkonium chloride) *1st line in lower risk patients*
Drapolene cream (cetrimide, benzalkonium chloride) *1st line in lower risk patients*
Cutimed protect - cream, spray, foam applicator *for higher risk patients- see criteria below*

1. Cutimed is the cost effective alternative barrier preparation to Cavilon. These are only indicated in certain situations:
   - **Peri-wound protection** film (spray, foam) indicated for protection from bodily fluids e.g. exudate
   - **Preventing incontinence dermatitis** in high risk patients (e.g. very acidic urine, diarrhoea)
     - Not all incontinence patients will require a barrier cream; professional judgement is required.
     - If skin is dry/fragile an emollient cream or gel could be applied after cleansing (apply sparingly).
     - Barrier creams can clog incontinence pads if applied too thickly.
   - **Stomas** Protecting broken or sore peristomal skin.
     - General barrier creams are NOT recommended as majority will reduce adhesion of bags/flanges.
     - Films/wipes reserved for selected patients only i.e. diabetics, palliative patients and difficult stomas
     - For acute prescription only
2. Zinc oxide, Sudocrem and Metanium are not recommended as they can become 'caked' making it difficult for healthcare workers to observe the skin properly and can also be difficult to remove.
3. Barrier creams should not routinely be prescribed for nappy rash in babies; suitable products are available OTC.

13.3 Topical local anaesthetics and antipruritics

For treatments of minor short term conditions such as insect bites and stings, patients are encouraged to self-care. Most insect bites and stings are not serious and will get better within a few hours or days. Over-the counter treatments can help ease symptoms, such as painkillers, creams for itching and antihistamines. Preparations containing crotamiton are of uncertain value therefore not routinely recommended.

13.4 Topical corticosteroids

Ointments are preferable to creams as they have a deeper, more prolonged emollient effect and increase the penetration of steroid. They are also less likely to cause irritation as they do not contain preservatives. Where possible, patients should be maintained on emollients only. If topical steroids are required for maintenance, there should be periods each year when they are withdrawn for as long as possible and emollients used on their own.

Eczema

NICE TA81 recommends that topical corticosteroids are first-line treatment for flare-ups of atopic eczema and should be prescribed for application only once or twice daily. Guidelines from the British Association of Dermatologist suggest that the best way of using topical corticosteroids is probably twice daily for 10-14 days when the eczema is active, followed by a 'holiday period of emollients only.

[1] UKMI. Medicines Q&A: Why is aqueous cream no longer recommended as a leave on moisturiser? January 2015

Psoriasis
See appendix 1 – psoriasis pathway and NICE Clinical Guideline 153 for advice on topical corticosteroids.

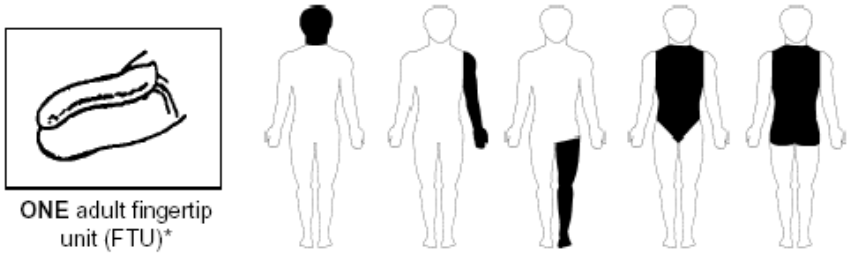
Mild	**Hydrocortisone** 0.5% cream 15g 1% cream/ ointment 15g, 30g, 50g 2.5% cream 15g
Moderate	**Eumovate** - *Clobetasone butyrate 0.05%* Cream/Ointment *30g £1.86* **Benovate RD -** *Betamethasone valerate 0.025%* Cream/Ointment *100g £3.15*
Alternative if Eumovate is not available	Haelan - *Fludroxycortide 0.0125%* Cream or Ointment 60g £3.26 Ultralanum Plain - *Fluocortolone 0.25*% Cream or ointment 50g £2.95
Potent	**Betnovate** *Betamethasone valerate 0.1%* Cream/Ointment 30g £1.43; 100g £4.05*;* Lotion 100ml £4.58
Alternative if Betnovate is not available	Locoid *Hydrocortisone Butyrate 0.1%* Cream/Ointment 30g £1.60; 100g £4.93
Very Potent	**Dermovate** – *Clobetasol propionate 0.05*% Cream/ ointment 30g £2.69, 100g £7.90

Corticosteroids with anti-infective preparations **–** *limited indications only*

Hydrocortisone/clotrimazole (Canesten HC) (Mild potency) cream 30g

1. Combination products containing a corticosteroid and an antibacterial preparation are not recommended. Topical steroids should not be used routinely on clinically infected skin unless the infection is being treated; a short course of a suitable oral antibiotic may be indicated.

Fingertip guide Patients who are prescribed steroids may be advised to use fingertip units (FTU) to measure the amount of steroid they need to apply to different parts of the body. A strip of cream or ointment equivalent to the length of the last joint of an adult's index finger is about half a gram.



ONE adult fingertip unit (FTU)*

Number of finger tip units (FTUs)

Age	Face & neck	Arm & hand	Leg & foot	Trunk (front)	Trunk (back) inc. buttocks
Adult	2½	4	8	7	7
Children:					
3-6 months	1	1	1½	1	1½
1-2 years	1½	1½	2	2	3
3-5 years	1½	2	3	3	3½
6-10 years	2	2½	4½	3½	5

* One adult fingertip unit (FTU) is the amount of ointment or cream expressed from a tube with a standard 5mm diameter nozzle, applied from the distal crease to the tip of the index finger.

13.5 Preparations for eczema and psoriasis
13.5.2 Preparations for Psoriasis
See appendix 1 – psoriasis pathway and NICE Clinical Guideline 153

Calcitriol (Silkis) ointment 100g
Calcipotriol (Dovonex) ointment 30g
Dithrocream 0.1%, 0.25%, 0.5%, 1%, 2% cream 50g
Betamethasone/Calcipotriol (Dovobet ointment 120g, Dovobet gel 60g, Enstilar Cutaneous Foam 60g) (see BNF advice on use of Dovobet and Enstilar Cutaneous Foam)
Psoriderm cream 225ml
Sebco scalp ointment 40g, 100g

1. See appendix 2 for guidance on prescribing of dovobet
2. Note the potential for confusion between Dovobet (calcipotriol and 0.05% betamethasone) and Dovonex (calcipotriol alone).
3. Dovobet should not be used in patients with guttate, pustular or erythrodermic psoriasis.
4. Do not add Dovobet as a repeat prescription medication.

13.5.3 Drugs affecting the immune response

1. **Pimecrolimus** and **tacrolimus** topical preparations are **'GREEN'** following consultant initiation
2. Pimecrolimus cream1% and tacrolimus ointment 0.03% are not recommended for use in children aged 2 years or below. Tacrolimus ointment 0.1% should not be used in children under 16 years of age.
3. Not to be put on repeat prescription.

13.6 Acne and Rosacea

13.6.1 Topical Preparations for Acne

For treatments of minor short term conditions such mild acne, patients are encouraged to self-care. Several creams, lotions and gels for treating acne are available at pharmacies (e.g. benzoyl peroxide products). Treatments can take up to three months to work.

Benzoyl peroxide preps 4% cream, 5% gel – note if supply issues Quinoderm 5% or 10% cream (also contains antimicrobial) are possible alternatives if unable to obtain benzoyl peroxide.

Azelaic acid (Skinoren) cream 20% 30g

Clindamycin (Dalacin T) solution, lotion 1% 30ml

Tretinoin (Aknemycin Plus) solution (erythromycin 4%, tretinoin 0.025%) 25ml

1. Benzoyl peroxide is suitable for most people with acne of all severities; start with lowest strength first to avoid reactions
2. Choice of combination products should be made according to individual preference and cost. Combination products are usually more expensive e.g. Duac Once Daily gel (clindamycin and benzoyl peroxide) or Epiduo gel (adapalene and benzoyl peroxide 2.5%) **BROWN** classification
3. If two separate products are used, they should be applied 12 hours apart.

13.6.2 Oral preparations for acne

See antibiotic chapter for recommended oral antibiotics used in the treatment of acne.

The use of minocycline in the management of acne is not recommended (DTB Vol 5 May 2013). This has been classified by the Derbyshire JAPC as **'BLACK'**.

Co-Cyprindiol tabs

1. Should be considered when topical or oral antibiotics have failed.
2. The benefits outweigh the risks in women of reproductive age for the treatment of:
   - Skin conditions related to androgen sensitivity (eg, severe acne with or without seborrhoea)
   - Hirsutism
3. May take up to 2-6 months to improve acne. The need to continue treatment should be evaluated periodically; treatment should be discontinued 3-4 menstrual cycles after the woman's acne has resolved.
4. Although it is an effective contraception (additional hormonal contraceptive should not be used in combination), it is not licensed for the sole purpose of contraception.
5. The risk of VTE is rare but this remains an important side effect. Healthcare professionals should be vigilant for signs and counsel patients to remain vigilant for signs and symptoms MHRA June 2013.
6. If patients present with severe depression co-cyprindiol should be stopped immediately – see SPC.

13.6.3 Topical preparations for rosacea

Brimonidine gel (Mirvaso) is classified by the Derbyshire JAPC as **'RED'** MHRA November 2016 have issued a warning regarding exacerbation of rosacea. MHRA June 2017 also advises to avoid application to irritated or damaged skin, including after laser therapy as systemic cardiovascular effects have been reported.

13.7 Preparations for warts and calluses

No preparations are included for the treatment of warts and calluses as there are many products available for purchase over-the-counter e.g. Salactol.

Anogenital Warts should be referred to the GUM clinic for treatment.

13.8 Sunscreens and camouflagers

13.8.1 Sunscreens JAPC classification **BROWN**

Sunscreens on FP10 require prescription endorsement 'ACBS'. The conditions for which they may be prescribed as per BNF include: for skin protection against UV radiation in abnormal cutaneous photosensitivity resulting from genetic disorders or photodermatoses, including vitiligo and those resulting from radiotherapy; chronic or recurrent herpes simplex labialis. SPF less than 30 should not normally be prescribed.

Sunscreen	SPF	Pack size & cost*	Cost/mL
Anthelios cream	50+	50mL x £3.80	0.08p
Sunsense Ultra lotion	50+	50mL x £5.01 125mL x £8.14 500mL x £18.17	0.10p 0.07p 0.04p
Uvistat cream/	30 50	125mL x £7.66 125mL x £8.68	0.06p 0.07p
Lip screen	50	5g x £2.99	--

***Mims November 2017**

13.8.1 Photodamage – preparations for actinic keratosis (see local AK pathway)

Fluorouracil 5% cream (Efudix) – **'GREEN'** after consultant / specialist initiation*
Ingenol mebutate gel (Picato) – **'GREEN'** after consultant / specialist initiation*
Fluorouracil 0.5%/salicylic acid 10% (Actikerall) – **'GREEN'** after consultant/specialist initiation*
Solaraze gel (diclofenac 3%, sodium hyaluronate 2.5%) – **'GREEN'** after consultant / specialist initiation*
*Specialist initiation includes GPwSI and GPs who have attended the Derbyshire AK pathway training

1. Imiquimod 5% is **'RED'** and restricted for specialist use.
2. Imiquimod 3.75% (Zyclara) is 'BLACK'; not routinely recommended or commissioned locally as this is less cost-effective than current standard therapy
3. Solaraze gel (diclofenac 3%, Sodium hyaluronate 2.5%) has occasionally been prescribed in error as a topical NSAID. This is very expensive.
4. Products should be prescribed as an acute script, and not added to repeat medication list.
5. The British Association of Dermatologists suggests that no therapy or emollient only are reasonable options for mild actinic keratosis and there is inadequate evidence to justify treatment of all lesions to prevent malignant change.

13.8.2 Camouflagers

Camouflagers on FP10 require prescription endorsement 'ACBS' when prescribed for postoperative scars and other deformities and as adjunctive therapy in the relief of emotional disturbances due to disfiguring skin diseases, such as vitiligo.

13.9 Shampoos and some other preparations for scalp & hair conditions

For treatments of minor short-term medical conditions patients are encouraged to self-care. For example:

Cradle cap in infants

Self-limiting and will clear up on its own without the need for treatment. BNF advice cradle cap in infants may be treated with coconut oil or olive oil applications followed by shampooing. See the BNF for the choice of coal tar shampoos.

Dandruff

The treatment of choice is the frequent use of a mild detergent shampoo once or twice weekly to rid the scalp of scale. Shampoos containing selenium sulphide are of no more value than other shampoos.

Eflornithine cream has been classified as a **BROWN** drug for facial Hirsutism in women. It offers very little benefit for the management of facial hirsutism in women. There is limited evidence for efficacy and patient satisfaction with eflornithine. Before considering eflornithine cream:

1. Women who are overweight or obese should be encouraged to lose weight
2. Women should be advised about other local methods of hair removal such as shaving and waxing.
3. Eflornithine should only be considered for use in women where alternative drug therapy e.g. co-cyprinidiol, is ineffective, not recommended, contra-indicated or considered inappropriate
4. Treatment with eflornithine does not remove hairs but slows down hair growth such that users require less frequent hair removal by other methods.
5. Treatment should be discontinued if no effects are seen within 4 months

Eflornithine cream is also classified as **GREEN** - Prescribing in adults off-license in primary care is permitted as per NHS England specialised services circular, Primary Care Responsibilities in Prescribing and Monitoring Hormone Therapy for Transgender and Non-Binary Adults. This should be done in close collaboration with the specialists at the Gender Identity Clinics

13.10 Anti-infective skin preparations
13.10.1 Antibacterial preparations

Polyfax ointment 4g, 20g	*First line for mild impetigo*
Fusidic Acid 2% (Fucidin) cream, oint 15g, 30g	*Local data shows the majority of Staph. aureus strains are resistant to fusidic acid*
Silver sulfadiazine cream 50, 250, 500g	*See wound management guideline*
Anabact (Metronidazole) gel 0.75% 15, 30g	*For malodorous wounds*
Rozex (Metronidazole) cream/gel 0.75% 30, 40g	*For rosacea*

13.10.2 Antifungal preparations
For treatments of minor, short-term medical conditions such as ringworm/athletes foot, patients are encouraged to self-care using treatments available over- the-counter.

Clotrimazole 1% cream 20g, 50g, spray 100g,	*1st line*
Terbinafine (Lamisil) 1% cream 15g, 30g	*2nd line*

1. Cutaneous fungal infections are most commonly due to dermatophytes (ringworm), candida and pityrosporum species. A fungal nail infection (onychomycosis) is mostly due to dermatophytes. Rarer cases of onychomycosis include candida and unusual moulds. It is recommended that whenever dermatophyte infection is suspected, skin scrapings and nail clippings are submitted for mycological confirmation prior to treatment.
2. Oral antifungals for nail infection are more effective than topical therapy (refer to Antimicrobial Treatment Guide)
3. There is limited evidence to support the use of topical nail antifungals. Where treatment is indicated and systemic therapy is contraindicated (e.g. renal or hepatic impairment) amorolfine is a treatment option. Examples of indications include where the condition is severe and debilitating, painful or in patients with peripheral vascular disease their use for cosmetic purposes is not supported. Tioconazole is **BLACK;** not a cost effective choice.

13.10.3 Antiviral preparation
For treatments of minor self-limiting conditions such as cold sore (usually clear up without treatment within 7-10 days) patients are encouraged to self-care. There are doubts over the efficacy of topical aciclovir in the management of recurrent herpes labialis. At best it offers only marginal benefits and only when started within a few hours of the first prodromal signs of an attack. It should not be prescribed and is available as an OTC preparation.

13.10.4 Parasiticidal preparations

Scabies
Permethrin 5% dermal cream 30g (1st line)
Malathion 0.5% aqueous liquid 50ml, 200ml

Head lice
For treatments of minor short term conditions such as head lice, self-care is encouraged. Treatments are available to purchase over-the-counter.

Combs
1. Combs are available to purchase over the counter. If prescription is necessary the most cost-effective comb can be prescribed.
2. Treatment should not be used unless a living, moving louse is detected.
3. Bug busting requires meticulous use; 30 minutes each time over the whole scalp at 4-day intervals for a minimum of 2 weeks and continued until no lice are found on 3 consecutive sessions

Dimeticone 4% lotion (Hedrin) 50ml, 150ml (1st line)
Malathion 0.5% aqueous liquid 50ml, 200ml

With each treatment choice:

- Use two applications seven days apart (12 hours/overnight contact time).
- 2-3 days after final application of insecticide: check hair thoroughly with a detector comb.
- If adult lice are present, then go on to next choice of treatment. Always thoroughly investigate the reasons for treatment failure e.g. incorrect use.

13.10.5 Preparations for minor cuts and abrasions

No preparations are included.

13.11 Disinfectants and cleansers

Sodium Chloride 0.9% (Normasol) solution 25ml, 100ml sachet

13.12 Antiperspirants

For treatments of minor conditions such as excessive sweating (hyperhidrosis) patients are encouraged to self-care.

Aluminium chloride hexahydrate 20% solution

Appendix 1 – Topical treatment strategies for adults with psoriasis (adapted from the BMJ 2012; 345 based on NICE CG153)

Trunk and limbs

Offer a potent corticosteroid (e.g. Betnovate) applied once daily plus vitamin D or a vitamin-D analogue (e.g. Silkis / calcitriol ointment) applied once daily (applied separately, one in the morning and the other in the evening) for up to 4 weeks as initial treatment

If there is little or no improvement at 4 weeks, discuss the next treatment option with the patient

If once-daily application of a potent corticosteroid plus once-daily application of vitamin D or a vitamin-D analogue does not result in clearance, or satisfactory control after a maximum of 8 weeks, offer vitamin D or a vitamin-D analogue alone applied twice daily (e.g. Silkis / calcitriol ointment)

If twice-daily application of vitamin D or a vitamin-D analogue (e.g. Silkis / calcitriol ointment) does not result in clearance, near clearance, or satisfactory control after 8-12 weeks, offer either:

- A potent corticosteroid (e.g. Betnovate) applied twice daily for up to 4 weeks or
- A coal tar preparation e.g. Psoriderm cream) applied once or twice daily

If a twice-daily potent corticosteroid (e.g. Betnovate) or coal tar preparation e.g. Psoriderm cream cannot be used, or a once-daily preparation would improve adherence, offer a combined product containing calcipotriol monohydrate and betamethasone diproprionate (e.g. Dovobet ointment or Enstilar foam if Dovobet ointment not tolerated))) applied once daily for up to 4 weeks

Face, flexures and genitals

Offer a short-term mild (e.g. hydrocortisone 1%) or moderate potency (e.g. Eumovate) corticosteroid* applied once or twice daily (for a maximum of 2 weeks)

If the response to short-term moderate potency corticosteroids is unsatisfactory, or they require continuous treatment to maintain control and there is serious risk of local corticosteroid-induced side-effects, offer a calcineurin inhibitor* applied twice daily for up to 4 weeks. Calcineurin inhibitors should be initiated by healthcare professionals with expertise in treating psoriasis Refer

Scalp

Offer a potent corticosteroid (e.g. Betnovate) applied once daily for up to 4 weeks as initial treatment

If treatment with a potent corticosteroid (e.g. Betnovate) does not result in clearance, near clearance, or satisfactory control after 4 weeks, consider:

- A different formulation of the potent corticosteroid (e.g. a shampoo or mousse) and/or
- Topical agents to remove adherent scale (e.g. agents containing salicylic acid, emollients, and oils e.g. Sebco ointment) before application of the potent corticosteroid

If the response to treatment with a potent corticosteroid (e.g. Betnovate) remains unsatisfactory after a further 4 weeks of treatment offer:

- A combined product containing calcipotriol monohydrate and betamethasone dipropionate* (e.g. Dovobet gel) applied once daily for up to 4 weeks or
- Vitamin D or a vitamin-D analogue (e.g. Silkis / calcitriol ointment) applied once daily (only in those who cannot use steroids and with mild to moderate scalp psoriasis)

If continuous treatment with either a combined product containing calcipotriol monohydrate and betamethasone diproprionate (e.g. Dovobet gel) applied once daily or vitamin D or a vitamin-D analogue (e.g. Silkis / calcitriol ointment) applied once daily for up to 8 weeks does not result in clearance, near clearance, or satisfactory control, offer:

- A very potent corticosteroid (e.g. Dermovate) applied for up to twice daily for 2 weeks or
- Coal tar applied once or twice daily or
- Referral to a specialist for additional support with topical applications and/or
- Advice on other treatment options

In people whose psoriasis has not responded satisfactorily* to a topical treatment strategy, before changing to an alternative treatment:

- Discuss with the person whether they have any difficulties with application, cosmetic acceptability, or tolerability and where relevant offer an alternative formulation
- Consider other reasons for non-adherence in line with NICE CG76

In adults not controlled with topical therapy, see full guideline for recommendations on:

- Phototherapy
- Systemic (non-biological) treatment

Appendix 2 – Guidance for General Practitioners on the use of Dovobet® ointment/gel and Enstilar Cutaneous Foamused in line with topical treatment strategies for adults with psoriasis above

Caution
Please note the potential for confusion between Dovo***bet*** (Calcipotriol and 0.05% Betamethasone) and Dovo***nex*** (calcipotriol alone)

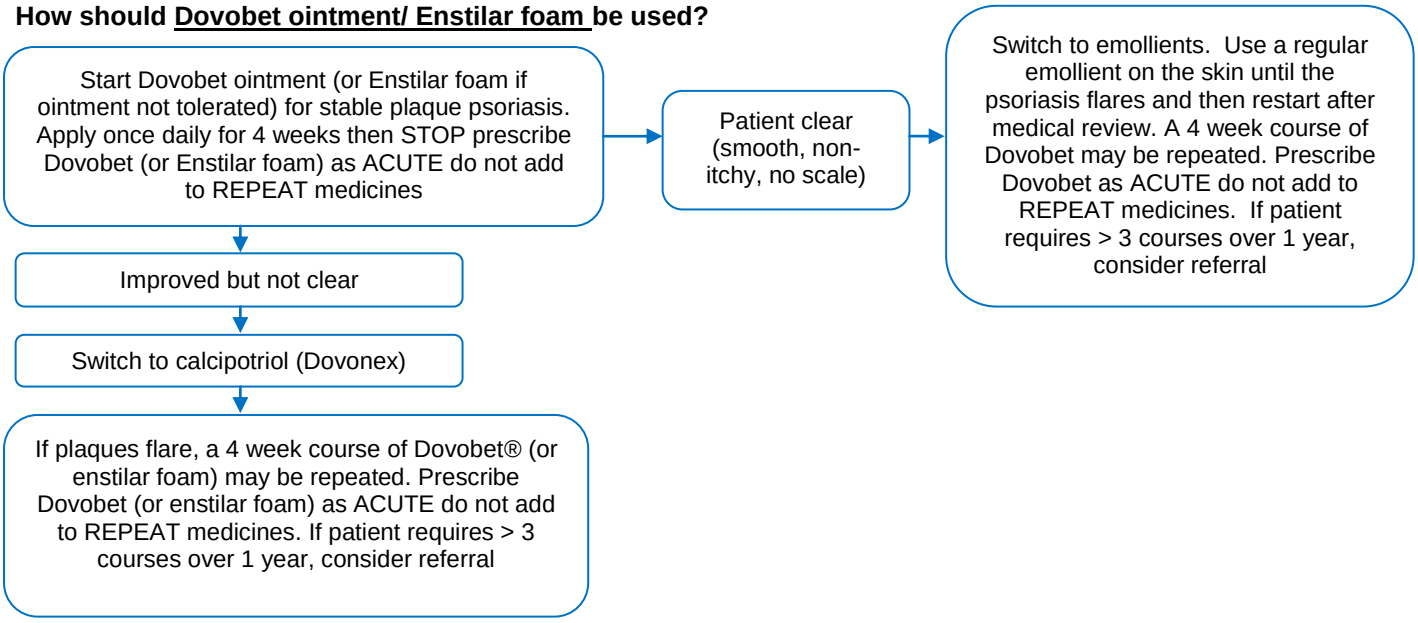
Dovobet should not be used in patients with guttate, pustular or erythrodermic psoriasis.

When should you prescribe Dovobet® ointment or Enstilar foam?

For patients with **stable** plaque psoriasis covering less than 30% body surface area who:

- have not responded to other topical treatments including Dovonex
- patients whom you feel may need secondary care intervention
- Enstilar (betamethasone/calcipotrol) is a new cutaneous foam formulation, indicated for plaque psoriasis. It is an alternative for patients who are unable to tolerate Dovobet ointment, use in line with Dovobet information below.

How should Dovobet ointment/ Enstilar foam be used?



When should you prescribe Dovobet® gel?

For patients with scalp psoriasis who:

- have not responded to other topical treatments

How should Dovobet gel be used?