

provided less specific information on their websites regarding alternative options. However, it is clear that implementation is highly variable. Although many visits may be follow-ups of chronic inflammatory conditions, for accurate diagnoses, high-resolution images are necessary, and still photographs may have a resolution advantage over video alone. Despite that, video, possibly because of reimbursement, was more widely implemented. Still images must be in focus, have multiple viewpoints, and clearly indicate the lesion or area of concern. Unfortunately, we found little previsit guidance. Our study suggests that, if reimbursement drove selection of video visits, it should be systematically compared with photography to evaluate outcomes. Second, this highlights practice gaps (eg, image production) in which American Academy of Dermatology patient guidelines may be useful.

Although our study evaluated early COVID-19 practices, future studies may be valuable in elucidating how teledermatology evolves.

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Prescription restrictions on hydroxychloroquine among the largest Florida pharmacy chains during the COVID-19 pandemic: An observational study



To the Editor: Hydroxychloroquine has long been used by dermatologists in the treatment of chronic disease, with use across such broad conditions as connective tissue disease, sarcoidosis, to lichen

planopilaris. The medication has generally enjoyed wide availability at a more affordable cost. Earlier this year, hydroxychloroquine became a household name after political leaders touted the drug's efficacy in the treatment and postexposure prophylaxis of COVID-19. As demand for hydroxychloroquine grew, pharmacies reported shortfalls in supply and began implementing restrictions on dispensation.¹ Our study seeks to characterize these restrictions in Florida-based locations of the nation's most profitable retail pharmacies.

The 6 largest pharmacies with locations in Florida (CVS, Walgreens, Walmart, Humana, Publix, and Costco) and 2 mail-order pharmacy companies (Cigna-Express Scripts and Optum Rx by UnitedHealth) were identified based on total prescription dispensing revenue in 2019.² April 2020 policies regarding dispensation limits for new prescriptions of hydroxychloroquine and prescription refills were obtained from online data, where available. Otherwise, dispensation limits were obtained by phone from corporate offices and, when redirected, confirmed with at least 3 local pharmacists at different locations.

Restriction limitations, when applicable, for new hydroxychloroquine prescriptions and prescription refills are summarized in [Table I](#). All pharmacies had strict limitations that prohibited new prescriptions in excess of a 14- or 30-day supply. Three pharmacies also reduced prescriptions for refills to 30-day supplies at a time ([Fig 1](#)). Our study identifies impacts to hydroxychloroquine prescribing practices in Florida's largest markets. It is a limitation of this study that only the largest pharmacy chains in the United States by revenue with locations serving Florida were evaluated.

The increased demand for hydroxychloroquine during the COVID-19 pandemic has resulted in heightened scrutiny of prescriptions. Amid the increasing demand and restrictions, patients with chronic dermatologic and rheumatologic conditions may be at harm; Michaud et al³ suggest that rheumatology patients have already begun rationing their medication regimens against professional advice because of shortages.³

A major concern lies in patients with new diagnoses of inflammatory and autoimmune conditions who require new prescriptions of hydroxychloroquine, now subject to more stringent quantity limits. Currently available data regarding the efficacy of hydroxychloroquine in the treatment of COVID-19 are conflicting,^{4,5} and the durability of this new indication for hydroxychloroquine remains to be seen. If current market demand for hydroxychloroquine continues to exceed supply, and large

Table I. Pharmacy prescription restrictions for hydroxychloroquine

Pharmacy	Total prescription dispensing revenue in 2019 across all drugs ³	Restrictions—patients requiring new prescriptions	Restrictions—refills for patients with established prescriptions
CVS Health	\$109 billion	14-day supply*	90-day supply [†]
Walgreens	\$84.3 billion	14-day supply [‡]	30-day supply [†]
Cigna/Express Scripts	\$45.8 billion	30-day supply ^{†,§}	90-day supply ^{†,§}
UnitedHealth Group OptumRx	\$25.8 billion	30-day supply ^{†,§,¶}	90-day supply ^{†,§}
Walmart	\$21.2 billion	30-day supply [†]	90-day supply [†]
Humana Pharmacy Solutions	\$6.9 billion	30-day supply [†]	30-day supply [†]
Publix	\$4 billion	30-day supply [†]	30-day supply [†]
Costco Wholesale Corp.	\$2.7 billion	14-day supply [‡]	90-day supply [†]

*Subsequent refills up to 90-day supply for US Food and Drug Administration–approved indications.

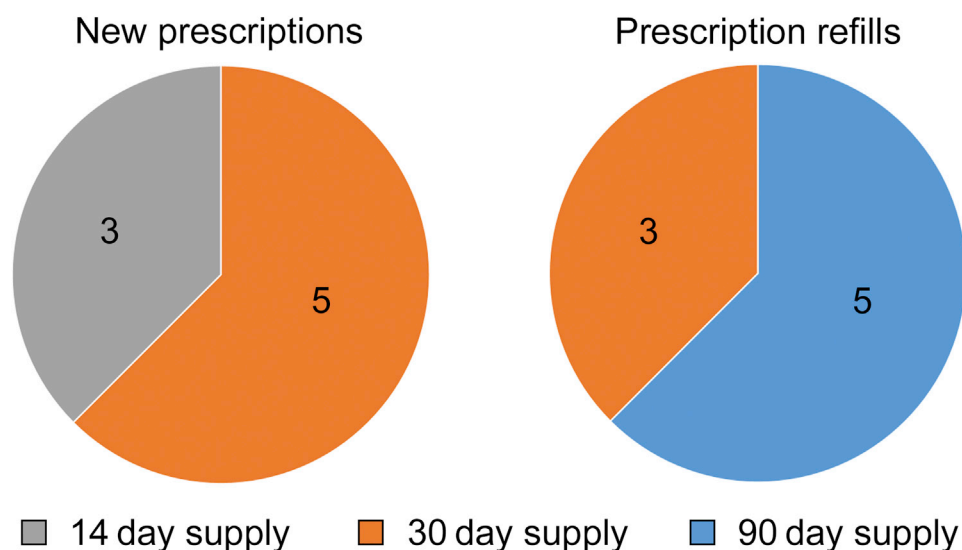
[†]Prescriptions filled only for US Food and Drug Administration–approved indications.

[‡]Subsequent refills limited to a 14-day supply.

[§]Additional preauthorization required.

[¶]Subsequent refills limited to a 30-day supply, up to 90 days with prior authorization.

Number of pharmacies with hydroxychloroquine prescription restrictions

**Fig 1.** Prescription restrictions for hydroxychloroquine.

national shortages for hydroxychloroquine continue to persist, subsequent prescription limitations may put dermatology patients at risk. Continued efforts should be made to ensure that medication is available for patients with chronic rheumatologic and dermatologic conditions that require hydroxychloroquine, including upholding proper prescribing practices by doctors. Dermatologists are called to self-police and limit prescriptions for hydroxychloroquine to those for dermatologic purposes. Dermatologists should also anticipate increased clarification queries on International Classification of Diseases codes and imposed quantity limits and

will face local variance in supply. Compounding and nonchain pharmacies may serve as supplementary sources to meet increased demand. Dermatologists must be aware of, and adapt to, identifiable changes in the market for hydroxychloroquine for the benefit of their patients.

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Challenges and countermeasures in the prevention of nosocomial infections of SARS-CoV-2 before resumption of work: Implications for the dermatology department



To the Editor: Recently, the number of new severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infections in China has been decreasing. At manuscript preparation, new cases had not been reported in Wuhan since March 18, 2020.¹ As health care systems resume routine clinical activities, implementation of robust infection control measures to prevent nosocomial transmission of SARS-CoV-2 remains a top priority.²

Our dermatology department is in Wuhan, the area first and worst affected by coronavirus disease 2019 in China. We aim to share our experiences in this unique position by outlining our infection control plan. We hope that it can serve as guidance for dermatology departments and the health agencies overseeing them.

In the early days of the outbreak, high rates of nosocomial SARS-CoV-2 infections were observed in health care workers. More than two-thirds of infected health care workers had contracted the virus in units without known coronavirus disease 2019 patients.³ We suspect that covert carriers of the virus may have contributed to this unchecked nosocomial spread; Qiu⁴ reported that 60% of infections may be asymptomatic. By remaining cognizant of this risk, even in departments not directly involved in treatment of coronavirus disease 2019, we devised the following infection control plan for our dermatology clinic:

First, an experienced infection control expert team was established. This team took responsibility for training and managing health care workers, including hand hygiene and the proper use of personal protective equipment (Supplemental Material 1 available via Mendeley at <https://data.mendeley.com/datasets/s3ncfct2z8/1>), as well as monitoring their state of health. We also held emergency simulations outlining protocols for inpatient dermatology admissions and consultations, as well as contingency plans for exposure to SARS-CoV-2—infected patients or health care workers in dermatology clinics.

Next, the department was divided into clean, potentially contaminated, and contaminated zones. The potentially contaminated and contaminated zones were separated by 2 buffer zones (Fig 1). Patients and staff were to use separate passageways. Before entering the designated patient care area (contaminated zone), staff would don personal protective equipment in the clean zone. On exiting the contaminated zone, they would follow a series of transitions before returning to the clean zone. In the first buffer zone, they doffed personal protective equipment (except working clothes, N95 masks, goggles, and caps). Then they entered the potentially contaminated zone to remove the remaining items. Next, they transitioned to the second buffer zone, where they donned a new surgical mask. Only then did they enter the clean zone. This functional and geographic division of the clinics and wards was designed to minimize the risk of cross contamination. By sanitizing and washing hands in each zone and using adequate personal protective equipment for all patient encounters, we lessened the risk of nosocomial transmission.

Finally, all employees were required to achieve 100% on a written examination (Supplemental Material 2). Thirty-five staff members completed the test (response rate 100%). Because of the relatively low accuracy rate of personal protective skills (82.04%) and division of work area (84.28%) (Fig 2), some dermatology staff received additional training.