

Move down to find and maintain lowest controlling therapy

Move up to improve control as necessary

TABLE 1: Suggested inhaler choices (on formulary) to step up or down from for NEW patients. ALL INHALERS MUST BE PRESCRIBED BY BRAND.

ENSURE DEVICE CONSISTENCY TO ENHANCE PATIENT COMPLIANCE AND REDUCE CONFUSION. CHECK INHALER TECHNIQUE AND COMPLIANCE WHENEVER STEPPING UP OR DOWN.

	SABA prn	Low dose ICS		Low dose ICS/LABA in combination inhaler.	Medium dose ICS/LABA in combination inhaler. PROVIDE STEROID CARD	High dose ICS/LABA in combination inhaler. PROVIDE STEROID CARD	
Dry powder Inhalers (DPI)	Salbutamol Easyhaler 100mcg 1-2 puffs PRN £3.31 (per 200 dose inhaler)	Easyhaler Budesonide 100 (200 doses/inhaler) 1-2 puffs BD £2.66-£5.32		Fobumix Easyhaler* (120) 160/4.5 1 puff BD £10.75 <i>80/4.5 can be used to step pts down if they can be maintained on a lower dose</i>	Fobumix Easyhaler* (120) 160/4.5 2 puffs BD £21.50 or 320/9 1 puff BD at £21.50	Fobumix Easyhaler (60) 320/9 2 puffs BD £43.00	
				Fostair NEXThaler (120) 100/6 1 puff BD £14.66	Fostair NEXThaler (120) 100/6 2 puffs BD £29.32	Fostair NEXThaler (120) 200/6 2 puffs BD £29.32	
		Flixotide 50mcg Accuhaler (60) 1 puff BD £4.00	Flixotide 100mcg Accuhaler (60) 1 puff BD £8.00	Relvar Ellipta (30 doses per inhaler) (Note: designated as both a low and medium dose) 92/22 1 puff OD £22.00		Relvar Ellipta (30) 184/22 1 puff OD £29.50	
		Pulmicort Turbohaler (200 doses/inhaler) 100mcg 2 puffs BD £8.55		DuoResp Spiromax* (120) 160/4.5 1 puff BD £13.99		DuoResp Spiromax (60) 320/9 1 puff BD £27.97	DuoResp Spiromax (60) 320/9 2 puffs BD £55.94
				Symbicort Turbohaler 100/6* (120) 2 puffs BD £28 (or 1 puff BD 200/6 £14)		Symbicort Turbohaler (120) 200/6 2 puffs BD £28	Symbicort Turbohaler(60) 400/12 2 puffs BD £56
Pressurised Metered-Dose Inhalers (pMDI)	Ventolin® Evohaler (Salbutamol) 100mcg 1-2 puffs prn £1.50 (200 dose)	Clenil Modulite 100mcg (200) 2 puffs BD £4.45	OR Qvar MDI /Easibreathe50mcg (200) 2 puffs BD £4.72/£4.64	Fostair 100/6* (120 doses per inhaler) 1 puff BD £14.66	Fostair 100/6* (120) 2 puffs BD £29.32	Fostair 200/6 (120) 2 puffs BD £29.32	
		Flixotide 50mcg Evohaler (120) 1 puff BD £2.72	Flixotide 50mcg Evohaler (120) 2 puffs BD £5.44	Seretide 50/25 Evohaler (120) 2 puffs BD £18.00 <i>(N.B. Sirdupla not available in 50/25)</i>	Sirdupla (or Seretide Evohaler) 125/25 (120) 2 puffs BD £26.25 (£35.00)	Sirdupla (or Seretide Evohaler) 250/25 (120) 2 puffs BD £44.61(£59.48)	
NOTES: * These inhalers can be used in a MART regime. See overleaf for further information.	PRN use of SABA may be sufficient in pts with mild intermittent or exercise-induced asthma. If patient is using ≥3 doses per week, step up.	NOTE: All costs quoted are for 30 days of treatment at the doses specified.		<ul style="list-style-type: none"> Note conflicting NICE / BTS guidance for this position. BTS (& GINA) advises ICS/LABA as 1st line here but NICE advise ICS +LTRA. NICE is based on most cost effective strategy but ICS/LABA is more clinically effective No response to LABA: stop & add LTRA. Some benefit but inadequate control: add LTRA. Consider ↑ICS dose or add tiotropium. 	Consider trials of: <ul style="list-style-type: none"> Increasing ICS up to high dose Addition of fourth drug e.g. LTRA, theophylline SR, Beta-agonist tablet, LAMA (Spiriva Respimat® tiotropium) If asthma remains uncontrolled after 3 months refer patient to secondary care for review/diagnosis check. Specialist may consider the use of a biologic agent or onward tertiary referral for more specialist options where appropriate.		

Grey inhalers: Non-formulary or not recommended inhalers. No new patients, existing patients only. Included in this guidance to inform step up/down for pts already on them.

Cost-effective inhaler choice: FOBUMIX. Considerable savings can be made by use of the Fobumix range when a ICS/LABA is required. Please do not use the 60 actuation 160/4.5 size inhaler which is less cost-effective, always use the 120 actuation size.

Adjusting therapy

- Patients should start an appropriate level of treatment according to the severity of their asthma.
- If treatment response is unexpectedly poor, reconsider diagnosis and check concordance, inhaler technique, smoking status & trigger factors before stepping up therapy and at every visit.
- When new treatments are added into a patients regimen, review them in 8 weeks.
- Complete asthma control should be achieved for 12 weeks before reducing down treatment.
- When treatment regimen is changed, review them again in 12 weeks time but inform the patient that they should step their treatment up again if they become symptomatic in this period.
- Do not reduce a patient's treatment regimen before 12 weeks of control as this could lead to exacerbations and hospital admissions. Patients using a medium or high dose ICS + LABA should NOT be advised to double-up their inhaler dose after an exacerbation.

Stepping down (see Table 1)

- The preferred approach is to reduce the ICS by approximately 50% whilst continuing the LABA at the same dose.
- This is straightforward for patients on high dose ICS but for patients on low-moderate ICS it is reasonable and more practical to reduce both (e.g. Fostair 100/6 2 puffs BD to Fostair 100/6 1 puff BD), as the alternative would be to require two separate inhalers

"Maintenance and reliever therapy" (MART) can be considered if:

- Inadequate asthma control + frequent need for reliever medication
- Previous asthma exacerbations requiring medical intervention
- Patients must have received education on the use of the inhaler as maintenance and reliever therapy, and clinicians must be confident patients understand how to use it appropriately.
- Patients should be advised to always have their inhaler available for rescue use.
- Patients requiring frequent use of rescue inhalations daily should be advised to return to the GP practice for review.
- Practices should monitor the number of prescriptions requested and any dose-related adverse effects.

Patient monitoring and information

- Each patient should have a personal asthma action plan in place.
- See: <https://www.asthma.org.uk/globalassets/health-advice/adult-asthma-action-plan.pdf>
- The RCP "three questions" (RCP3Q) is recommended for use within QOF as a way of assessing asthma control as follows:
 - *Have you had difficulty sleeping because of your asthma symptoms (including cough)?*
 - *Have you had your usual asthma symptoms during the day (cough, wheeze, chest tightness or breathlessness)?*
 - *Has your asthma interfered with your usual activities (e.g. housework, work/school etc)?*

If the score is 0 (indicates good asthma control) plus no exacerbations then its ok to step down

- **Useful Inhaler technique assessment videos and leaflets can be found here:**
<https://www.prescqipp.info/newsfeed/launched-inhaler-technique-assessment-videos-and-leaflets-b163>

The 6 measures of Complete Asthma Control

No	•Daytime Symptoms
No	•Night-time awakening due to asthma
No	•Need for rescue medication
No	•Asthma attacks/exacerbations
No	•Limitation on activity including exercise
Normal	•Lung function (FEV1 and/or PEF >80% predicted or best)

With minimal side effects from medication

Refer to secondary care if:

- Any doubt about diagnosis.
- Recent admission to hospital for poorly controlled asthma (& not already arranged).
- Continued uncontrolled asthma symptoms.
- There is complicating multi-morbidity.
- Consideration of monoclonal antibody therapy (omalizumab for allergic asthma, mepolizumab for eosinophilic asthma)
- Treatment for complicating lung conditions (e.g. vasculitis, allergic bronchopulmonary aspergillosis or bronchiectasis).
- ≥2 courses of oral corticosteroids in 12 months.

People who received treatment in hospital or through out-of-hours services for an acute exacerbation of asthma should be followed up by their own GP practice within 2 working days.