Clinical Guideline for the Diagnosis, Evaluation and Management of Adults and Children with Asthma

Color Key

- Four Components of Asthma Care
- Classifying Asthma Severity, Assessing Asthma Control and the Stepwise Approach for Managing Asthma in Children Aged 0–4 years
- Classifying Asthma Severity, Assessing Asthma Control and the Stepwise Approach for Managing Asthma in Children Aged 5–11 years
- Classifying Asthma Severity, Assessing Asthma Control and the Stepwise Approach for Managing Asthma in Children > 12 Years of Age & Adults
- Long-Term Control Medications: Estimated Comparative Daily Dosages
- Long-Term Control Medications: Usual Dosages
- Quick Relief Medications

Guidelines are intended to be flexible. They serve as recommendations, not rigid criteria. Guidelines should be followed in most cases, but depending on the patient, and the circumstances, guidelines may need to be tailored to fit individual needs.
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Criteria that suggest the diagnosis of asthma:

Consider a diagnosis of asthma and perform spirometry if any of these indicators are present*:

- The symptoms of dyspnea, cough and/or wheezing, especially nocturnal, difficulty breathing or chest tightness;
- With acute episodes: hyperinflation of thorax, decreased breath sounds, high pitched wheezing, and use of accessory muscles;
- Symptoms worse in presence of exercise, viral infections, inhaled allergens, irritants, changes in weather, strong emotional expression, stress, menstrual cycles;
- Reversible airflow obstruction: FEV1 >12% from baseline or increase in FEV1 >10% of predicted after inhalation of bronchodilator, if able to perform spirometry;

*Eczema, hay fever, and/or a family history of asthma or atopic diseases are often associated with asthma, but they are not key indicators.

Goal of Therapy: Control of Asthma

Reduce Impairment

- Prevent chronic and troublesome symptoms (e.g., coughing or breathlessness in the daytime, in the night, or after exertion).
- Require infrequent use (< 2 days a week) of inhaled short-acting beta2-agonist (SABA) for quick relief of symptoms (not including prevention of exercise-induced bronchospasm [EIB]).
- Maintain (near) normal pulmonary function.
- Maintain normal activity levels (including exercise and other physical activity and attendance at school or work).
- Meet patients' and families' expectations of and satisfaction with asthma care.

Reduce Risk

- Prevent recurrent exacerbations of asthma and minimize the need for emergency department (ED) visits or hospitalizations.
- Prevent loss of lung function; for children, prevent reduced lung growth.
- Provide optimal pharmacotherapy with minimal or no adverse effects of therapy.
Four Components of Asthma Care

1. Assessment and Monitoring of Asthma Severity and Control

Assessment and monitoring of asthma are tied to the concepts of severity, control and responsiveness and the domains of impairment and risk.

For assessing asthma severity and asthma control by impairment and risk, see age specific charts.

Components of Asthma Assessment

Medical history and physical exam:

- Assess and document asthma severity and control, including impairment and risk domains.
- Spirometry recommended for patients ≥ 2 years:
  1. at time of initial assessment;
  2. after treatment has begun and symptoms and peak expiratory flow (PEF) have stabilized;
  3. during periods of low asthma control and (4) at least every 1–2 years.
- Identify or review triggers and precipitating factors (e.g., allergens, exercise, upper respiratory infection, tobacco smoke, chemicals, weather, stress emotions).
- Assess family, psychological, occupational history including stressors.
- Assess medication use, including CAM*. At every visit, review beta-agonist use.
- Assess for co-morbidities (HIV, sindsitus, GERD**, obesity, ABBPA**, OSA***, stress or depression).
- Conduct physical exam focusing on upper and lower airways, nose and skin.
- Assess impact of asthma on patient and family, patient and family perception of disease, and knowledge and skills for self management.
  * complementary alternative medicine, ** gastroesophageal reflux disease, *** allergic bronchopulmonary aspergillosis, **** obstructive sleep apnea.

Recommended Approach to Care Management

Initial asthma visit

- Assess severity using both the impairment and risk domains (See Classifying Asthma Severity and Initiating Treatment in specific age charts).
- Perform spirometry measurement (FEV1, FVC, FEV1/FVC) in all patients ≥ 5 years old before and after the patient inhales a SABA.
- Assess skills for self management, including medication administration technique.
- Prescribe appropriate pharmacological therapy based on severity assessment (See age specific stepwise chart).
- Develop and review Asthma Action Plan and provide education.
- Monitor at least at 2–6 week intervals until control is achieved.

Chronic maintenance asthma visit

- Assess asthma control based on impairment and risk (See Classifying Asthma Control and Adjusting Therapy in specific age charts).
- Perform spirometry measurement (FEV1, FVC, FEV1/FVC) in all patients ≥ 5 years old at least every 1–2 years when asthma is stable, more often when asthma is unstable, or when clinically indicated by a change in the patient’s condition or medication.
- Consider validated questionnaires to assess impairment and the Asthma Control Test (ACT) (www.asthmacomfort.com) and the Asthma Control Questionnaire (ACQ) (www.qoltech.co.uk/index.htm).
- Step up or step down treatment based on assessment of control (See age specific stepwise chart).
- Update and review written Asthma Action Plan.
- Provide inactivated influenza vaccine for all patients over 6 months of age, unless a vaccine contraindication exists.
- Provide 23-Valent Pneumococcal Polysaccharide Vaccine (PPSV23) to adults 19 to 64 years of age (see: http://www.cdc.gov/vaccines/recs/schedules/default.htm).
- Provide 1 dose of PPSV23 to children aged ≥ 2 years requiring treatment with high-dose oral corticosteroid therapy. For the appropriate timing see the ACIP schedule at: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr911a1.htm's_cid=rr911a1_e.
- Review methods of reducing exposure to relevant allergens and irritants.
- Provide education, emphasizing medication adherence and medication administration techniques.
- Schedule an appointment for asthma at least every 6 months after asthma control is achieved and prior to predicted seasonal exacerbations.

Acute exacerbation asthma visit

- Do not underestimate the severity of an exacerbation. Severe exacerbations can be life threatening and can occur in patients at any level of asthma severity or control.
- Perform spirometry for patients ≥ 5 years during periods of loss of asthma control.
- Prescribe appropriate pharmacological therapy based on assessment of severity and control (See age specific stepwise chart).
- Provide a rescue plan of systemic corticosteroids or other medications if needed for acute exacerbations at any step.
- Check patient's inhaler, spacer/holding chamber, and peak flow technique.
- Review symptom/peak flow monitoring.
- Provide education, emphasizing medication adherence and medication administration technique.
- Review methods of reducing exposure to relevant allergens and irritants.
- Update and review written Asthma Action Plan.
- Monitor closely until control is achieved.

Referrals

Asthma Specialist

Consider referral to asthma specialist such as an allergist or pulmonologist when:

- Patient has had a life-threatening asthma exacerbation;
- Patient is not meeting the goals of asthma therapy after 3–6 months of treatment. An earlier referral or consultation is appropriate if the physician concludes that the patient is unresponsive to therapy.
- Signs and symptoms are atypical, or there are problems in differential diagnosis;
- Other conditions complicate asthma or its diagnosis, e.g., sinusitis, nasal polyposis, ABPA, severe rhinitis, vocal cord dysfunction (VCD), GERD, chronic obstructive pulmonary disease (COPD);
- Additional diagnostic testing is indicated (e.g., allergy skin testing, rhinoscopy, complete pulmonary function studies, provocative challenge, bronchoscopy);
- Patient requires additional education and guidance on complications of therapy, problems with adherence, or allergen avoidance.
- Patient is being considered for immunotherapy;
- Patient requires step 4 care or higher (step 3 for children 0–4 years of age).
- Consider referral if patient requires step 3 care (step 2 for children 0–4 years of age) (See age specific stepwise charts);
- Patient has required more than two bursts of oral corticosteroids in 1 year or has an exacerbation requiring hospitalisation;
- Patient requires confirmation of a history that suggests that an occupational or environmental inhalant or ingested substance is provoking or contributing to asthma. Depending on the complexities of diagnosis, treatment, or the intervention required in the work environment, it may be appropriate in some cases for the specialist to manage the patient over a period of time or to co-manage with the primary care provider (PCP).

Behavioral Specialist

Refer patients with significant psychiatric, psychosocial, or family stressors, which adversely affect their asthma control, to a behavioral health professional for treatment.

Health Plan and Community Agencies

- Contact individual health plan, local health department, or community agency for availability of:
  - Individualized case management;
  - Individualized asthma education;
  - Asthma classes/support groups;
  - Smoking cessation classes;
  - Assistance with durable medical equipment and medical supplies such as peak flow meters, spacer/holding chambers, nebulizers and compressors;
  - Home or school environmental assessment and remediation when possible.

Occupational Lung Disease

- Notify the New York State Department of Health Occupational Lung Disease registry at 1-866-807-2130 for patients suspected of having occupational asthma/lung disease. Services may include education and workplace evaluation.

Managing Special Situations

Patients who have asthma may encounter situations that will require adjustments to their asthma management to keep their asthma under control, such as EIB, pregnancy, and surgery.
Four Components of Asthma Care (Continued)


- Exercise-Induced Bronchospasm (EIB): EIB should be anticipated in all asthma patients. A history of cough, shortness of breath, chest pain or tightness, wheezing, or endurance problems during exercise suggests EIB.

- Pregnancy: Maintaining adequate control of asthma during pregnancy is important for the health of the mother and her baby. Monitor asthma status during prenatal visits. Albuterol is the preferred short acting beta agonist (SABA). Inhaled corticosteroids (ICS), particularly budesonide, are the preferred long term control medication because of documented safety and efficacy.

- Surgery: Patients who have asthma are at risk for specific complications during and after surgery.

2. Education for a Partnership in Care

- A partnership between the clinician and the person who has asthma (and the caregiver, for children) is required for effective asthma management.

- Asthma self-management education improves patient outcomes and can be cost effective.

- Asthma education and self management support should be tailored to the patient’s asthma; e.g., allergens, irritants, tobacco smoke.

- Identifying and avoiding environmental exposures that worsen the patient’s asthma.

- Using a written asthma action plan to know when and how to:
  - Take daily actions to control asthma;
  - Adjust medication in response to signs of worsening asthma;
  - Seek medical care as appropriate.

- Effective allergen avoidance requires a comprehensive approach (such as a multifaceted allergen-control education program provided in the home setting); single steps alone are generally ineffective.

- Manage, if present, allergic bronchopulmonary aspergillosis (ABPA), gastroesophageal reflux disease (GERD), obesity or overweight patients, obstructive sleep apnea (OSA), rhinitis/sinusitis, chronic stress/depression.

Environmental Control Measures

- If patients with asthma are exposed to irritants or inhalant allergens to which they are sensitive, their asthma symptoms may increase and precipitate an asthma exacerbation. Substantially reducing exposure to these factors may reduce inflammation, symptoms, and need for medication.

For the patient’s environment the provider should:

- Assess patient’s exposure to and clinical significance of: irritants (e.g. tobacco smoke, smoke from wood burning stoves and fireplaces, dust generated by vacuum cleaning, and substances with strong odors and sprays, includ-

- irant volatile organic compounds [VOCs], chemicals); exercise or sports and allergens (e.g. animal dander, dust mites, cockroaches, mold, pollen, chem-


- Counsel, provide information and refer patients to appropriate services to reduce exposure to relevant allergens/irritants and prevent infections where possible.

- For example: Tobacco Smoke Exposure
  - Assess for smoking and exposure to second hand smoke;
  - Routinely advise and encourage patients and families to quit smoking;
  - Strongly advise against smoking indoors or in automobiles;
  - Initiate and/or refer to smoking cessation interventions and counseling and consider pharmacotherapy for patients and household members;
  - Inform patients that smoking cessation information and FREE Stop Smoking Kits are available through the New York State Smoker’s Quitline. The toll-free number is 1-888-697-8487, or visit the website at www.nysmokefree.com.

- Effective allergen avoidance requires a comprehensive approach (such as a multifaceted allergen-control education program provided in the home setting); single steps alone are generally ineffective.

- Consider subcutaneous immunotherapy for patients who have allergies at steps 2-4 of care (mild or moderate persistent asthma) when there is a clear relationship between symptoms and exposure to an allergen to which the patient is sensitive.

Co-morbidity Management

- Manage, if present, allergic bronchopulmonary aspergillosis (ABPA), gastroesophageal reflux disease (GERD), obesity or overweight patients, obstructive sleep apnea (OSA), rhinitis/sinusitis, chronic stress/depression.
4. Medications

Stepwise Approach to Asthma Management

(See Stepwise Approach for Managing Asthma in age specific charts)

- The stepwise approach incorporates all four components of care:
  1. Assessment of severity to initiate therapy or assessment of control to monitor and adjust therapy;
  2. Patient education;
  3. Environmental control measures, and management of co-morbid conditions at every step; and
  4. Selection of medication.

- The type, amount, and scheduling of medication is determined by the level of asthma severity or asthma control.

- Therapy is increased (stepped up) as necessary and decreased (stepped down) when possible. Gain control as quickly as possible, then decrease treatment to the least medication necessary to maintain control. The preferred approach is to start with more intensive therapy in order to more rapidly suppress airway inflammation and thus gain prompt control.

- ICSs are the most consistently effective anti-inflammatory therapy for all age groups, at all steps of care for persistent asthma and the preferred first line treatment that results in improved asthma control.

- Provide a rescue plan of systemic corticosteroids or other medications if needed for acute exacerbations at any step.

- Spacers/holding chambers should be used with metered dose inhalers (MDIs).

See Long-Term Control and Quick-Relief charts for medications and usual dosages.

Check for availability and the health plan/insurance formulary when applicable.

Bibliography


www.alvesco.us

www.dulera.com


Classifying Asthma Severity & Initiating Treatment in Children 0–4 Years of Age

Assessing severity and initiating therapy in children who are not currently taking long-term control medication

<table>
<thead>
<tr>
<th>Components of Severity</th>
<th>Classification of Asthma Severity: Children 0–4 Years of Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Intermittent</td>
</tr>
<tr>
<td>Nighttime awakenings</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td></td>
</tr>
<tr>
<td>1–2x/month</td>
<td></td>
</tr>
<tr>
<td>3–4x/month</td>
<td></td>
</tr>
<tr>
<td>&gt;1x/week</td>
<td></td>
</tr>
<tr>
<td>Short-acting beta2-agonist use for symptom control (not prevention of EIB)</td>
<td></td>
</tr>
<tr>
<td>≤2 days/week</td>
<td></td>
</tr>
<tr>
<td>&gt;2 days/week but not daily</td>
<td></td>
</tr>
<tr>
<td>Daily</td>
<td></td>
</tr>
<tr>
<td>Throughout the day</td>
<td></td>
</tr>
</tbody>
</table>

Risk

<table>
<thead>
<tr>
<th>Exacerbations requiring oral systemic corticosteroids</th>
<th>0–1/year (see note)</th>
<th>≥2 exacerbations in 6 months requiring oral systemic corticosteroids, or ≥4 wheezing episodes/1 year lasting &gt;1 day AND risk factors for persistent asthma</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consider severity and interval since last exacerbation. Frequency and severity may fluctuate over time.</td>
<td>Exacerbations of any severity may occur in patients in any severity category.</td>
<td>In 2–6 weeks, depending on severity, evaluate level of asthma control that is achieved. If no clear benefit is observed in 4–6 weeks, consider adjusting therapy or alternative diagnoses.</td>
</tr>
</tbody>
</table>

Notes:
- Level of severity is determined by both impairment and risk. Assess impairment domain by caregiver’s recall of previous 2–4 weeks. Assign severity to the most severe category in which any feature occurs.
- At present, there are inadequate data to correspond frequencies of exacerbations with different levels of asthma severity. For treatment purposes, patients who had ≥2 exacerbations requiring oral systemic corticosteroids in the past 6 months, or ≥4 wheezing episodes in the past year, and who have risk factors for persistent asthma may be considered the same as patients who have persistent asthma, even in the absence of impairment levels consistent with persistent asthma.

Classifying severity in patients after asthma becomes well controlled, by lowest level of treatment required to maintain control

<table>
<thead>
<tr>
<th>Lowest level of treatment required to maintain control (See Stepwise Charts for Treatment Steps.)</th>
<th>Classification of Asthma Severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>intermittent</td>
<td>Mild</td>
</tr>
<tr>
<td>Persistent</td>
<td>Moderate</td>
</tr>
<tr>
<td>Mild</td>
<td>Severe</td>
</tr>
<tr>
<td>Step 1</td>
<td>Step 2</td>
</tr>
<tr>
<td>Step 3 and consider short course of oral systemic corticosteroids</td>
<td></td>
</tr>
</tbody>
</table>

Notes:
- For population-based evaluations, clinical research, or characterization of a patient’s overall asthma severity after control is achieved. For clinical management, the focus is on monitoring the level of control, not the level of severity, once treatment is established.

Assessing Asthma Control & Adjusting Therapy in Children 0–4 Years of Age

<table>
<thead>
<tr>
<th>Components of Control</th>
<th>Classification of Asthma Control: Children 0–4 Years of Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Well Controlled</td>
</tr>
<tr>
<td>Nighttime awakenings</td>
<td>≤2 days/week</td>
</tr>
<tr>
<td>Interference with normal activity</td>
<td>w1x/month</td>
</tr>
<tr>
<td>Short-acting beta2-agonist use for symptom control (not prevention of EIB)</td>
<td>≤2 days/week</td>
</tr>
<tr>
<td>Exacerbations requiring oral systemic corticosteroids</td>
<td>0–1/year</td>
</tr>
<tr>
<td>Treatment-related adverse effects</td>
<td>Medication side effects can vary in intensity from none to very troublesome and worrisome. The level of intensity does not correlate to specific levels of control but should be considered in the overall assessment of risk.</td>
</tr>
</tbody>
</table>

Recommended Action for Treatment

- Maintain current treatment.
- Regular followup every 1–6 months.
- Consider step down if well controlled for at least 3 months.
- Step up 1 step, and
- Reevaluate in 2–6 weeks.
- If no clear benefit in 4–6 weeks, consider alternative diagnoses or adjusting therapy.
- For side effects, consider alternative treatment options.
- Consider short course of oral systemic corticosteroids.
- Step up 1–2 steps, and
- Reevaluate in 2 weeks.
- If no clear benefit in 4–6 weeks, consider alternative diagnoses or adjusting therapy.
- For side effects, consider alternative treatment options.

Before step up in therapy:
- Review adherence to medication, inhaler technique, and environmental control. If alternative treatment was used, discontinue it and use preferred treatment for that step.

Notes:
- The level of control is based on the most severe impairment or risk category. Assess impairment domain by caregiver’s recall of previous 2–4 weeks. Symptom assessment for longer periods should reflect a global assessment, such as inquiring whether the patient’s asthma is better or worse since the last visit.
- At present, there are inadequate data to correspond frequencies of exacerbations with different levels of asthma control. In general, more frequent and intense exacerbations (e.g., requiring urgent, unscheduled care, hospitalization, or ICU admission) indicate poorer disease control. For treatment purposes, patients who had ≥2 exacerbations requiring oral systemic corticosteroids in the past year may be considered the same as patients who have not-well-controlled asthma, even in the absence of impairment levels consistent with not-well-controlled asthma.
Stepwise Approach for Managing Asthma in Children 0–4 Years of Age

Intermittent Asthma
Consult with asthma specialist if step 4 care or higher is required. Consider consultation at step 3.

Persistent Asthma: Daily Medication

Step 1
- Preferred: SABA PRN
- Alternative: Cetirizine or Omalizumab

Step 2
- Preferred: Low-dose ICS
- Alternative: Cromolyn or Montelukast

Step 3
- Preferred: Medium-dose ICS

Step 4
- Preferred: Medium-dose ICS + either LABA or Montelukast

Step 5
- Preferred: High-dose ICS + either LABA or Montelukast

Step 6
- Preferred: Oral systemic corticosteroids

Quick-Relief Medication for All Patients
- SABA as needed for symptoms. Intensity of treatment depends on severity of symptoms.
- With viral respiratory infection: SABA q 4–6 hours up to 24 hours (longer with physician consult). Consider short course of oral systemic corticosteroids if exacerbation is severe or patient has history of previous severe exacerbations.
- CAUTION: Frequent use of SABA may indicate the need to step up treatment.

Key: Alphabetical order is used when more than one treatment option is listed within either preferred or alternative therapy. ICS, inhaled corticosteroid; LABA, inhaled long-acting beta2-agonist; SABA, inhaled short-acting beta2-agonist.

Notes:
- If alternative treatment is used and response is inadequate, discontinue it and use the preferred treatment before stepping up.
- If clear benefit is not observed within 4–6 weeks and patient/family medication technique and adherence are satisfactory, consider adjusting therapy or alternative diagnosis.

Each Step: Patient education, environmental control, and management of comorbidities.
### Classifying Asthma Severity & Initiating Treatment in Children 5–11 Years of Age

#### Components of Severity

<table>
<thead>
<tr>
<th>Impairment</th>
<th>Intermittent</th>
<th>Classification of Asthma Severity: Children 5–11 Years of Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms</td>
<td>≤2 days/week</td>
<td>Mild: &gt;2 days/week but not daily  Moderate: &gt;1x/week but not nightly  Severe: Throughout the day</td>
</tr>
<tr>
<td>Nighttime awakenings</td>
<td>≤2x/month</td>
<td>3–4x/month  &gt;1x/month but not nightly  Often 7x/week</td>
</tr>
<tr>
<td>Short-acting beta-agonist use for symptom control (not prevention of EIB)</td>
<td>≤2 days/week</td>
<td>2 days/week but not daily  Daily  Several times per day</td>
</tr>
<tr>
<td>Interference with normal activity</td>
<td>None</td>
<td>Minor limitation  Some limitation  Extremely limited</td>
</tr>
<tr>
<td>Lung function</td>
<td>Normal FEV₁, between exacerbations  FEV₁ &gt; 80% predicted  FEV₁/FVC &gt; 85%</td>
<td>FEV₁ = &gt; 80% predicted  FEV₁/FVC = 75–80%  FEV₁/FVC &lt; 75%  FEV₁/ &lt; 60% predicted</td>
</tr>
</tbody>
</table>

#### Risk

<table>
<thead>
<tr>
<th>Exacerbations requiring oral systemic corticosteroids</th>
<th>0–1/year (see note)</th>
<th>≥2 in 1 year (see note)</th>
</tr>
</thead>
</table>

#### Notes:

- Level of severity is determined by assessment of both impairment and risk. Assess impairment domain by patient’s/caregiver’s recall of previous 2–4 weeks and spirometry. Assign severity to the most severe category in which any feature occurs.
- At present, there are inadequate data to correspond frequencies of exacerbations with different levels of asthma severity. In general, more frequent and intense exacerbations (e.g., requiring urgent, unscheduled care, hospitalization, or ICU admission) indicate greater underlying disease severity. For treatment purposes, patients who had 2 exacerbations requiring oral corticosteroids in the past 6 months, or 4 wheezing episodes in the past year, and who have risk factors for persistent asthma may be considered the same as patients who have persistent asthma, even in the absence of impairment levels consistent with persistent asthma.

### Assessing Asthma Control & Adjusting Therapy in Children 5–11 Years of Age

#### Components of Control

<table>
<thead>
<tr>
<th>Impairment</th>
<th>Well Controlled</th>
<th>Not Well Controlled</th>
<th>Very Poorly Controlled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms</td>
<td>≤2 days/week but not more than once on each day</td>
<td>&gt;2 days/week or multiple times on ≤2 days/week</td>
<td>Throughout the day</td>
</tr>
<tr>
<td>Nighttime awakenings</td>
<td>≤1x/month</td>
<td>≥2x/month  ≥2x/week</td>
<td></td>
</tr>
<tr>
<td>Interference with normal activity</td>
<td>None</td>
<td>Some limitation  Extremely limited</td>
<td></td>
</tr>
<tr>
<td>Short-acting beta-agonist use for symptom control (not prevention of EIB)</td>
<td>≤2 days/week</td>
<td>&gt;2 days/week  Several times per day</td>
<td></td>
</tr>
<tr>
<td>Lung Function: FEV₁ or peak flow</td>
<td>&gt;80% predicted/personal best</td>
<td>60–80% predicted/personal best  60% predicted/personal best</td>
<td></td>
</tr>
<tr>
<td>≥80%</td>
<td>&lt;75%</td>
<td></td>
<td></td>
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</tbody>
</table>

#### Risk

<table>
<thead>
<tr>
<th>Exacerbations requiring oral systemic corticosteroids</th>
<th>0–1/year (see note)</th>
<th>&gt;2/year (see note)</th>
</tr>
</thead>
</table>

#### Treatment-related adverse effects

- Medication side effects can vary in intensity from none to very troublesome and worrisome. The level of intensity does not correlate to specific levels of control but should be considered in the overall assessment of risk.

#### Recommended Action for Treatment

- **Before step up in therapy:**
  - Review adherence to medication, inhaler technique, and environmental control. If alternative treatment was used, discontinue it and use preferred treatment for that step.

- **Step 1:**
  - Maintain current step.
  - Regular follow up every 1–6 months.
  - Consider step down if well controlled for at least 3 months.

- **Step 2:**
  - Step up at least 1 step, and
  - Reevaluate in 2–6 weeks.
  - For side effects, consider alternative treatment options.

- **Step 3:**
  - Consider short course of oral systemic corticosteroids.
  - Step up 1–2 steps, and
  - Reevaluate in 2 weeks.
  - For side effects, consider alternative treatment options.

#### Notes:

- The level of control is based on the most severe impairment or risk category. Assess impairment domain by patient’s/caregiver’s recall of previous 2–4 weeks and by spirometry/or peak flow measures. Symptom assessment for longer periods should reflect a global assessment, such as inquiring whether the patient’s asthma is better or worse since the last visit.
- At present, there are inadequate data to correspond frequencies of exacerbations with different levels of asthma control. In general, more frequent and intense exacerbations (e.g., requiring urgent, unscheduled care, hospitalization, or ICU admission) indicate poorer disease control. For treatment purposes, patients who had 2 exacerbations requiring oral corticosteroids in the past year may be considered the same as patients who have not-well-controlled asthma, even in the absence of impairment levels consistent with persistent asthma.
**Stepwise Approach for Managing Asthma in Children 5–11 Years of Age**

### Intermittent Asthma

Consult with asthma specialist if step 4 care or higher is required. Consider consultation at step 3.

### Persistent Asthma: Daily Medication

Each Step: Patient education, environmental control, and management of comorbidities. Steps 2–4: Consider subcutaneous allergen immunotherapy for patients who have allergic asthma (see notes).

#### Step 1

**Preferred:** SABA PRN

#### Step 2

**Preferred:** Either: Low-dose ICS or Cromolyn, LTRA, or Theophylline

**Alternative:** SABA

#### Step 3

**Preferred:** Medium-dose ICS + LABA

**Alternative:** Medium-dose ICS + either LTRA or Theophylline

#### Step 4

**Preferred:** High-dose ICS + LABA

**Alternative:** High-dose ICS + either LTRA or Theophylline

#### Step 5

**Preferred:** High-dose ICS + LABA + oral systemic corticosteroid

**Alternative:** High-dose ICS + either LTRA or Theophylline + oral systemic corticosteroid

### Quick-Relief Medication for All Patients

- SABA as needed for symptoms. Intensity of treatment depends on severity of symptoms: up to 3 treatments at 20-minute intervals as needed. Short course of oral systemic corticosteroids may be needed.

- **CAUTION:** Increasing use of SABA or use >2 days a week for symptom relief (not prevention of EIB) generally indicates inadequate control and the need to step up treatment.

---

Key: Alphabetical order is used when more than one treatment option is listed within either preferred or alternative therapy. ICS, inhaled corticosteroid; LABA, inhaled long-acting beta2-agonist; LTRA, leukotriene receptor antagonist; SABA, inhaled short-acting beta2-agonist.

Notes:

- If alternative treatment is used and response is inadequate, discontinue it and use the preferred treatment before stepping up.
Classifying Asthma Severity & Initiating Treatment in Youths ≥12 Years of Age & Adults

### Components of Severity

<table>
<thead>
<tr>
<th>Impairment</th>
<th>Classification of Asthma Severity: Youths ≥12 Years of Age &amp; Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal FEV1/FVC</td>
<td>Intermittent</td>
</tr>
<tr>
<td>≥2 days/week</td>
<td>&gt;2 days/week but not daily</td>
</tr>
<tr>
<td>≤2x/month</td>
<td>3–4x/month</td>
</tr>
<tr>
<td>≤2x/week</td>
<td>&gt;2 days/week but not daily and not more than 1x on any day</td>
</tr>
</tbody>
</table>

### Risk

1. Exacerbations requiring oral systemic corticosteroids
   - 0–1/year (see note)
   - ≥2 in 1 year (see note)
   - Consider severity & interval since last exacerbation. Frequency & severity may fluctuate over time for patients in any severity category.
   - Relative annual risk of exacerbations may be related to FEV1.

### Notes:
- Level of severity is determined by assessment of both impairment and risk. Assess impairment domain by patient’s/caregiver’s recall of previous 2–4 weeks and spirometry. Assign severity to the most severe category in which any feature occurs.
- At present, there is inadequate data to correspond frequencies of exacerbations with different levels of asthma severity. In general, more frequent and intense exacerbations (e.g., requiring urgent, unscheduled care, hospitalization, or ICU admission) indicate greater underlying disease severity. For treatment purposes, patients who had ≥2 exacerbations requiring oral systemic corticosteroids in the past year may be considered the same as patients who have persistent asthma, even in the absence of impairment levels consistent with persistent asthma.

### Classifying severity in patients after asthma becomes well controlled, by lowest level of treatment required to maintain control*

#### Components of Control

<table>
<thead>
<tr>
<th>Impairment</th>
<th>Classification of Asthma Control: Youths ≥12 Years of Age &amp; Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well Controlled</td>
<td>Not Well Controlled</td>
</tr>
<tr>
<td>Symptoms</td>
<td>≤2 days/week</td>
</tr>
<tr>
<td>Nighttime awakenings</td>
<td>≤2x/month</td>
</tr>
<tr>
<td>Interference with normal activity</td>
<td>None</td>
</tr>
<tr>
<td>Short-acting beta2-agonist use for symptom control (not prevention of EIB)</td>
<td>≤2 days/week</td>
</tr>
<tr>
<td>Lung Function: FEV1 or peak flow</td>
<td>&gt;80% predicted/personal best</td>
</tr>
</tbody>
</table>

#### Risk

1. Exacerbations requiring oral systemic corticosteroids
   - 0–1/year (see note)
   - ≥2/year (see note)

### Key:
- FEV1, forced expiratory volume in 1 second; FVC, forced vital capacity; ICU, intensive care unit.
- *For population-based evaluations, clinical research, or characterization of a patient’s overall asthma severity after control is achieved. For clinical management, the focus is on monitoring the level of control, not the level of severity, once treatment is established.

### Notes:
- For population-based evaluations, clinical research, or characterization of a patient’s overall asthma severity after control is achieved. For clinical management, the focus is on monitoring the level of control, not the level of severity, once treatment is established.

### Assessing Asthma Control & Adjusting Therapy in Youths ≥12 Years of Age & Adults

#### Components of Control

<table>
<thead>
<tr>
<th>Impairment</th>
<th>Classification of Asthma Control: Youths ≥12 Years of Age &amp; Adults</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
<tr>
<td>Interference with normal activity</td>
<td>None</td>
</tr>
<tr>
<td>Short-acting beta2-agonist use for symptom control (not prevention of EIB)</td>
<td>≤2 days/week</td>
</tr>
<tr>
<td>Lung Function: FEV1 or peak flow</td>
<td>&gt;80% predicted/personal best</td>
</tr>
</tbody>
</table>

#### Risk

1. Exacerbations requiring oral systemic corticosteroids
   - 0–1/year (see note)
   - ≥2/year (see note)

### Key:
- FEV1, forced expiratory volume in 1 second; FVC, forced vital capacity; ICU, intensive care unit.
- *For population-based evaluations, clinical research, or characterization of a patient’s overall asthma severity after control is achieved. For clinical management, the focus is on monitoring the level of control, not the level of severity, once treatment is established.

### Notes:
- For population-based evaluations, clinical research, or characterization of a patient’s overall asthma severity after control is achieved. For clinical management, the focus is on monitoring the level of control, not the level of severity, once treatment is established.

### Classifying severity in patients after asthma becomes well controlled, by lowest level of treatment required to maintain control*

#### Components of Control

<table>
<thead>
<tr>
<th>Impairment</th>
<th>Classification of Asthma Control: Youths ≥12 Years of Age &amp; Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well Controlled</td>
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</tr>
<tr>
<td>Symptoms</td>
<td>≤2 days/week</td>
</tr>
<tr>
<td>Nighttime awakenings</td>
<td>≤2x/month</td>
</tr>
<tr>
<td>Interference with normal activity</td>
<td>None</td>
</tr>
<tr>
<td>Short-acting beta2-agonist use for symptom control (not prevention of EIB)</td>
<td>≤2 days/week</td>
</tr>
<tr>
<td>Lung Function: FEV1 or peak flow</td>
<td>&gt;80% predicted/personal best</td>
</tr>
</tbody>
</table>

#### Risk

1. Exacerbations requiring oral systemic corticosteroids
   - 0–1/year (see note)
   - ≥2/year (see note)

### Key:
- FEV1, forced expiratory volume in 1 second; FVC, forced vital capacity; ICU, intensive care unit.
- *For population-based evaluations, clinical research, or characterization of a patient’s overall asthma severity after control is achieved. For clinical management, the focus is on monitoring the level of control, not the level of severity, once treatment is established.

### Notes:
- For population-based evaluations, clinical research, or characterization of a patient’s overall asthma severity after control is achieved. For clinical management, the focus is on monitoring the level of control, not the level of severity, once treatment is established.

### Assessing Asthma Control & Adjusting Therapy in Youths ≥12 Years of Age & Adults

#### Components of Control

<table>
<thead>
<tr>
<th>Impairment</th>
<th>Classification of Asthma Control: Youths ≥12 Years of Age &amp; Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well Controlled</td>
<td>Not Well Controlled</td>
</tr>
<tr>
<td>Symptoms</td>
<td>≤2 days/week</td>
</tr>
<tr>
<td>Nighttime awakenings</td>
<td>≤2x/month</td>
</tr>
<tr>
<td>Interference with normal activity</td>
<td>None</td>
</tr>
<tr>
<td>Short-acting beta2-agonist use for symptom control (not prevention of EIB)</td>
<td>≤2 days/week</td>
</tr>
<tr>
<td>Lung Function: FEV1 or peak flow</td>
<td>&gt;80% predicted/personal best</td>
</tr>
</tbody>
</table>

#### Risk

1. Exacerbations requiring oral systemic corticosteroids
   - 0–1/year (see note)
   - ≥2/year (see note)

### Key:
- FEV1, forced expiratory volume in 1 second; FVC, forced vital capacity; ICU, intensive care unit.
- *For population-based evaluations, clinical research, or characterization of a patient’s overall asthma severity after control is achieved. For clinical management, the focus is on monitoring the level of control, not the level of severity, once treatment is established.

### Notes:
- For population-based evaluations, clinical research, or characterization of a patient’s overall asthma severity after control is achieved. For clinical management, the focus is on monitoring the level of control, not the level of severity, once treatment is established.

### Assessing Asthma Control & Adjusting Therapy in Youths ≥12 Years of Age & Adults

#### Components of Control

<table>
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<tr>
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</tr>
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<tbody>
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<td>Well Controlled</td>
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</tr>
<tr>
<td>Symptoms</td>
<td>≤2 days/week</td>
</tr>
<tr>
<td>Nighttime awakenings</td>
<td>≤2x/month</td>
</tr>
<tr>
<td>Interference with normal activity</td>
<td>None</td>
</tr>
<tr>
<td>Short-acting beta2-agonist use for symptom control (not prevention of EIB)</td>
<td>≤2 days/week</td>
</tr>
<tr>
<td>Lung Function: FEV1 or peak flow</td>
<td>&gt;80% predicted/personal best</td>
</tr>
</tbody>
</table>

#### Risk

1. Exacerbations requiring oral systemic corticosteroids
   - 0–1/year (see note)
   - ≥2/year (see note)

### Key:
- FEV1, forced expiratory volume in 1 second; FVC, forced vital capacity; ICU, intensive care unit.
- *For population-based evaluations, clinical research, or characterization of a patient’s overall asthma severity after control is achieved. For clinical management, the focus is on monitoring the level of control, not the level of severity, once treatment is established.

### Notes:
- For population-based evaluations, clinical research, or characterization of a patient’s overall asthma severity after control is achieved. For clinical management, the focus is on monitoring the level of control, not the level of severity, once treatment is established.
### Stepwise Approach for Managing Asthma in Youths >12 Years of Age & Adults

#### Intermittent Asthma

Each Step: Patient education, environmental control, and management of comorbidities. 

Steps 2–4: Consider subcutaneous allergen immunotherapy for patients who have allergic asthma.

#### Stepwise Medication

<table>
<thead>
<tr>
<th>Step 1</th>
<th>Step 2</th>
<th>Step 3</th>
<th>Step 4</th>
<th>Step 5</th>
<th>Step 6</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preferred:</strong></td>
<td><strong>Preferred:</strong></td>
<td><strong>Preferred:</strong></td>
<td><strong>Preferred:</strong></td>
<td><strong>Preferred:</strong></td>
<td><strong>Preferred:</strong></td>
</tr>
<tr>
<td>SABA PRN</td>
<td>Low-dose ICS</td>
<td>Medium-dose ICS + LABA or Medium-dose ICS + either LTRA, Theophylline, or Zileuton</td>
<td>Medium-dose ICS + LABA or Medium-dose ICS + either LTRA, Theophylline, or Zileuton</td>
<td>High-dose ICS + LABA + oral corticosteroid and Consider Omalizumab for patients who have allergies</td>
<td>High-dose ICS + LABA + oral corticosteroid and Consider Omalizumab for patients who have allergies</td>
</tr>
<tr>
<td><strong>Alternative:</strong></td>
<td><strong>Alternative:</strong></td>
<td><strong>Alternative:</strong></td>
<td><strong>Alternative:</strong></td>
<td><strong>Alternative:</strong></td>
<td><strong>Alternative:</strong></td>
</tr>
<tr>
<td>Cromolyn, LTRA, or Theophylline</td>
<td>Low-dose ICS + LABA or Medium-dose ICS + either LTRA, Theophylline, or Zileuton</td>
<td>Low-dose ICS + LABA or Medium-dose ICS + either LTRA, Theophylline, or Zileuton</td>
<td>High-dose ICS + LABA and Consider Omalizumab for patients who have allergies</td>
<td>SABA or use &gt;2 days week for symptom relief (not prevention of EIB) generally indicates inadequate control and the need to step up treatment.</td>
<td></td>
</tr>
</tbody>
</table>

**Key:** Alphabetical order is used when more than one treatment option is listed within either preferred or alternative therapy. ICS, inhaled corticosteroid; LABA, inhaled long-acting beta2-agonist; LTRA, leukotriene receptor antagonist; SABA, inhaled short-acting beta2-agonist.

**Notes:**
- If alternative treatment is used and response is inadequate, discontinue it and use the preferred treatment before stepping up.

**Quick-Relief Medication for All Patients**
- SABA as needed for symptoms. Intensity of treatment depends on severity of symptoms: up to 3 treatments at 20-minute intervals as needed. Short course of oral systemic corticosteroids may be needed.
- **CAUTION:** Increasing use of SABA or use >2 days a week for symptom relief (not prevention of EIB) generally indicates inadequate control and the need to step up treatment.
## Long-Term Control Medications

### Estimated Comparative Daily Doses for Inhaled Corticosteroids

<table>
<thead>
<tr>
<th>Medication</th>
<th>Low Daily Dose</th>
<th>Medium Daily Dose</th>
<th>High Daily Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Child 0–4 Years of Age</td>
<td>Child 5–11 Years of Age</td>
<td>≥12 Years of Age &amp; Adults</td>
</tr>
<tr>
<td>Beclomethasone HFA</td>
<td>NA</td>
<td>80–160 mcg</td>
<td>&gt;160–320 mcg</td>
</tr>
<tr>
<td>40 or 80 mcg/puff</td>
<td>NA</td>
<td>80–240 mcg</td>
<td>&gt;240–480 mcg</td>
</tr>
<tr>
<td>Budesonide DPI</td>
<td>NA</td>
<td>180–400 mcg</td>
<td>&gt;400–800 mcg</td>
</tr>
<tr>
<td>90, 180, or 200 mcg/inhalation</td>
<td>NA</td>
<td>180–600 mcg</td>
<td>&gt;600–1,200 mcg</td>
</tr>
<tr>
<td>Budesonide Inhaled Inhalation suspension</td>
<td>0.25–0.5 mg</td>
<td>&gt;0.5–1.0 mg</td>
<td>&gt;1.0 mg</td>
</tr>
<tr>
<td>for nebulization</td>
<td>0.5 mg</td>
<td>1.0 mg</td>
<td>2.0 mg</td>
</tr>
<tr>
<td>Ciclesonide</td>
<td>NA</td>
<td>160 mcg</td>
<td>&gt;0.5–1.0 mg</td>
</tr>
<tr>
<td>80 or 160 mcg/actuation</td>
<td>NA</td>
<td>NA</td>
<td>&gt;0.5–1.0 mg</td>
</tr>
<tr>
<td>Fluticasone HFA/MDI</td>
<td>44 mg</td>
<td>88–176 mcg</td>
<td>&gt;176–352 mcg</td>
</tr>
<tr>
<td>110 or 220 mcg/puff</td>
<td>176 mcg</td>
<td>88–264 mcg</td>
<td>&gt;264–440 mcg</td>
</tr>
<tr>
<td>Fluticasone DPI</td>
<td>100–200 mcg</td>
<td>100–300 mcg</td>
<td>&gt;200–400 mcg</td>
</tr>
<tr>
<td>50–100, or 250 mcg/inhalation</td>
<td>NA</td>
<td>100–300 mcg</td>
<td>&gt;300–500 mcg</td>
</tr>
<tr>
<td>Mometasone DPI#</td>
<td>110 mcg#</td>
<td>220 mcg</td>
<td>440 mcg</td>
</tr>
<tr>
<td>110 or 220 mcg/inhalation</td>
<td>110 mcg#</td>
<td>220 mcg</td>
<td>440 mcg</td>
</tr>
</tbody>
</table>

**Key:** DPI, dry powder inhaler; HFA, hydrofluoroalkane; MDI, metered-dose inhaler; NA, not available (either not approved, no data available, or safety and efficacy not established for this age group).

# For children 4 to 11 years of age: Mometasone starting dose and maximum dose are the same, 110 mcg/day. See: www.asmanex.com.

**Therapeutic Issues:**
- The most important determinant of appropriate dosing is the clinician’s judgment of the patient’s response to therapy. The clinician must monitor the patient’s response on several clinical parameters and adjust the dose accordingly. Once control of asthma is achieved, the dose should be carefully titrated to the minimum dose required to maintain control.
- Preparations are not interchangeable on a mcg or per puff basis. This figure presents estimated comparable daily doses. See EPR-3 Full Report 2007 for full discussion.
- Some doses may be outside package labeling, especially in the high-dose range. Budesonide nebulizer suspension is the only inhaled corticosteroid (ICS) with FDA-approved labeling for children <4 years of age.
- For children <4 years of age: The safety and efficacy of ICSs in children <1 year has not been established. Children <4 years of age generally require delivery of ICS (budesonide and fluticasone HFA) through a face mask that should fit snugly over nose and mouth and avoid nebulizing in the eyes. Wash face after each treatment to prevent local corticosteroid side effects. For budesonide, the dose may be administered 1–3 times daily. Budesonide suspension is compatible with albuterol, ipratropium, and levalbuterol nebulizer solutions in the same nebulizer. Use only jet nebulizers, as ultrasonic nebulizers are ineffective for suspensions. For fluticasone HFA, the dose should be divided 2 times daily; the low dose for children <4 years of age is higher than for children 5–11 years of age due to lower dose delivered with face mask and data on efficacy in young children.
- Children <2 years of age (please refer to package insert for age appropriateness, drug interactions and potential adverse effects).
- Above list not all inclusive. Check for availability and health plan/insurance formulary when applicable. Use of spacer/holding chamber is recommended with use of metered-dose inhaler (MDI).
### Long-Term Control Medications

#### Usual Doses for Long-Term Control Medications*

<table>
<thead>
<tr>
<th>Medication</th>
<th>0–4 Years of Age</th>
<th>5–11 Years of Age</th>
<th>≥12 Years of Age &amp; Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inhaled Corticosteroids</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Systemic Corticosteroids</td>
<td>Methylnprednisolone 2, 4, 8, 16, 32 mg tablets</td>
<td>0.25–2 mg/kg daily in single dose in a.m. or qod as needed for control</td>
<td>0.25–2 mg/kg daily in single dose in a.m. or qod as needed for control</td>
</tr>
<tr>
<td></td>
<td>Prednisolone 5 mg tablets, 5 mg/3 cc, 15 mg/5 cc</td>
<td>Short-course &quot;burst&quot;: 1–2 mg/kg/day, maximum 60 mg/day for 3–10 days</td>
<td>Short-course &quot;burst&quot;: 1–2 mg/kg/day, maximum 60 mg/day for 3–10 days</td>
</tr>
<tr>
<td></td>
<td>Prednisone 1, 2, 5, 10, 20, 50 mg tablets, 5 mg/cc, 5 mg/5 cc</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **Inhaled Long-Acting Beta2-Agonists** (LABAs) | Salmeterol DPI: 50 mcg/ blister | 1 blister, q 12 hours | 1 blister, q 12 hours | 1 blister, q 12 hours |
|**Formoterol** DPI: 12 mcg/single-use capsule | NA | 1 capsule, q 12 hours | 1 capsule, q 12 hours | 1 capsule, q 12 hours |

| **Combined Medication** | Fluticasone/Salmeterol* DPI: 100 mcg/50 mcg, 250 mcg/50 mcg, or 500 mcg/50 mcg, HFA: 45 mcg/21 mcg, 115 mcg/21 mcg, 230 mcg/21 mcg | DPI Diskus for > 4 years of age | DPI only | 1 inhalation bid, dose depends on level of severity or control |
|                        | Budesonide/Formoterol HFA MDI: 80 mcg/4.5 mcg, 160 mcg/4.5 mcg | NA | 2 puffs, bid, dose depends on | 2 puffs, bid, dose depends on |
|                        | Mometasone/Formoterol Mediation** HFA MDI: 100 mcg/5 mcg, 200 mcg/5 mcg | NA | N/A | 2 inhalations bid, dose depends on prior asthma therapy and asthma control |
| **Cromolyn** | Nebulizer 20 mg/ampule | 1 ampule qid (NA <2 years of age) | 1 ampule qid | 1 ampule qid |

| **Immunomodulators** | Omalizumab (Anti-IgE) Subcutaneous injection, 150 mg/1.2 ml following reconstitution with 1.4 ml sterile water for injection | NA | NA | 150–375 mg SC q 2–4 weeks, depending on body weight and pretreatment serum IgE level |

| **Leukotriene Modifiers** | Montelukast 4 mg or 5 mg chewable tablet 4 mg granule packets 10 mg tablet | 4 mg qhs (1–5 years of age) | 5 mg qhs (6–14 years of age) | 10 mg qhs |
|                          | Zafirlukast 10 mg tablet, 20 mg tablet | NA | 10 mg bid (7–11 years of age) | 40 mg daily (20 mg tablet bid) |

| **5-Lipoxygenase Inhibitor** | Zileuton 600 mg | NA | NA | 2,400 mg daily (give tablets qid) |
|                            | Zileuton CR 600 mg tablet extended-release tablet | NA | NA | 2,400 mg daily (give two extended-release tablets bid) |

| **Methylxanthines** | Theophylline Liquids, sustained-release tablets, and capsules | Starting dose 10 mg/kg/day, usual maximum: *<1 year of age: 0.2 (age in weeks) +5 = mg/kg/day *<1 year of age: 16 mg/kg/day | Starting dose 10 mg/kg/day, usual maximum: 16 mg/kg/day | Starting dose 10 mg/kg/day up to 300 mg maximum, usual maximum 800 mg/day |

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Key: DPI, dry powder inhaler; EIB, exercise-induced broncospasm; HFA, hydrofluoroalkane; ICS, inhaled corticosteroids; IgE, immunoglobulin E; MDI, metered-dose inhaler; NA, not available (either not approved, no data available, or safety and efficacy not established for this age group); SABA, short-acting beta2-agonist.

* See www.advair.com

**NOTE:** Dosages are provided for those products that have been approved by the U.S. Food and Drug Administration or have sufficient clinical trial safety and efficacy data in the appropriate age ranges to support their use. For advisories and other relevant information see www.fda.gov/medwatch.

Above list not all inclusive. Check for availability and health plan/insurance formulary when applicable. Use of spacer/holding chamber is recommended with use of metered-dose inhaler (MDI).
### Usual Doses for Quick-Relief Medications*

For quick-relief medications for asthma exacerbations, other than Albuterol, see NAEPP EPR-3 Summary Report 2007, NIH Publication number 08-5846, pages 53-60. (www.nhlbi.nih.gov/guidelines/asthma/asthsumm.pdf, page 53)

#### Inhaled Short-Acting Beta₂-Agonists

<table>
<thead>
<tr>
<th>Medication</th>
<th>&lt;5 Years of Age</th>
<th>5–11 Years of Age</th>
<th>≥12 Years of Age &amp; Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Albuterol HFA MDI</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>96 mcg/puff; 60 puffs/canister or 200 puffs/canister</td>
<td>2 puffs every 4–6 hours, as needed for symptoms; 1–2 puffs 5 minutes before exercise</td>
<td>2 puffs every 4–6 hours, as needed for symptoms; 2 puffs 5 minutes before exercise</td>
<td>2 puffs every 4–6 hours, as needed for symptoms; 2 puffs 5 minutes before exercise</td>
</tr>
<tr>
<td><strong>Albuterol Nebulizer Solution</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.63 mg/3 mL, 1.25 mg/3 mL, 2.5 mg/3 mL, 5 mg/mL (0.5%)</td>
<td>0.63–2.5 mg in 3 cc of saline q 4–6 hours, as needed</td>
<td>1.25–5 mg in 3 cc of saline q 4–8 hours, as needed</td>
<td>1.25–5 mg in 3 cc of saline q 4–8 hours, as needed</td>
</tr>
<tr>
<td><strong>Levalbuterol HFA</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>48 mcg/puff; 200 puffs/canister</td>
<td>NA</td>
<td>2 puffs every 4–6 hours, as needed for symptoms; 2 puffs 5 minutes before exercise</td>
<td>2 puffs every 4–6 hours, as needed for symptoms; 2 puffs 5 minutes before exercise</td>
</tr>
<tr>
<td><strong>Levalbuterol (R-albuterol) Nebulizer Solution</strong></td>
<td>0.31–1.25 mg in 3 cc, q 4–6 hours, as needed for symptoms; 2 puffs 5 minutes before exercise</td>
<td>0.31–0.63 mg, q 8 hours, as needed for symptoms</td>
<td>0.63–1.25 mg, q 8 hours, as needed for symptoms</td>
</tr>
</tbody>
</table>

#### Quick-Relief Medications

*NOTE: Dosages are provided for those products that have been approved by the U.S. Food and Drug Administration or have sufficient clinical trial safety and efficacy data in the appropriate age ranges to support their use. For advisories and other relevant information see www.fda.gov/medwatch.

Above list not all inclusive. Check for availability and health plan/insurance formulary when applicable. Use of spacer/holding chamber is recommended with use of metered-dose inhaler (MDI).

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**Anticholinergics**

<table>
<thead>
<tr>
<th>Medication</th>
<th>&lt;5 Years of Age</th>
<th>5–11 Years of Age</th>
<th>≥12 Years of Age &amp; Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ipratropium HFA MDI</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17 mcg/puff, 200 puffs/canister</td>
<td>NA</td>
<td>NA</td>
<td>2–3 puffs q 6 hours</td>
</tr>
<tr>
<td><strong>Ipratropium HFA Nebulizer solution</strong></td>
<td>0.25 mg/mL (0.025%)</td>
<td>NA</td>
<td>0.25 mg q 6 hours</td>
</tr>
<tr>
<td><strong>Ipratropium with albuterol MDI</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 mcg/puff of ipratropium bromide and 103 mcg/puff of albuterol; 200 puffs/canister</td>
<td>NA</td>
<td>NA</td>
<td>2–3 puffs q 6 hours</td>
</tr>
<tr>
<td><strong>Ipratropium with albuterol spray inhalation</strong></td>
<td>25 mcg ipratropium bromide/100 mcg albuterol sulfate</td>
<td>NA</td>
<td>1 inhalation q 4–6h maximum 6 inhalations/day</td>
</tr>
<tr>
<td><strong>Ipratropium with albuterol</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.5 mg/3 mL, 1.25 mg/3 mL, 2.5 mg/3 mL, 5 mg/mL (0.5%)</td>
<td>0.13 mg/kg (minimum dose 2.5 mg) every 20 minutes for 3 doses then 0.13–0.3 mg/kg up to 10 mg every 1–4 hours as needed, or 0.5 mg/kg/hour by continuous nebulization</td>
<td>2.5–5 mg every 20 minutes up to 4 hours, then every 1–4 hours as needed.</td>
<td></td>
</tr>
</tbody>
</table>

**Systemic Corticosteroids**

<table>
<thead>
<tr>
<th>Medication</th>
<th>&lt;5 Years of Age</th>
<th>5–11 Years of Age</th>
<th>≥12 Years of Age &amp; Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Methylprednisolone</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2, 4, 6, 8, 16, 32 mg tablets</td>
<td>NA</td>
<td>NA</td>
<td>3 mL</td>
</tr>
<tr>
<td><strong>Prednisone</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 mg tablets; 5 mg/5 cc, 15 mg/5 cc</td>
<td>5 mg/kg/day, maximum 60 mg/day, for 3–10 days</td>
<td>Short course “burst”: 1–2 mg/kg/d for 3–10 days</td>
<td>Short course “burst”: 40–60 mg/day as single or 2 divided doses for 3–10 days</td>
</tr>
<tr>
<td><strong>Prednisone</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1, 2.5, 5, 10, 20, 50 mg tablets; 5 cc/cc, 5 mg/5 cc</td>
<td>5 mg/kg/IM once</td>
<td>240 mg IM once</td>
<td>240 mg IM once</td>
</tr>
</tbody>
</table>

**Repository injection (Methylprednisolone acetate)**

40, 80 mg/mL

7.5 mg/kg IM once

240 mg IM once

240 mg IM once

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**Key:** CFC, chlorofluorocarbon; ED, emergency department; EIB, exercise-induced bronchospasm; HFA, hydrofluoroalkane; IM, intramuscular; MDI, metered-dose inhaler; NA, not available (either not approved, no data available, or safety and efficacy not established for this age group); PEF, peak expiratory flow; SABA, short-acting beta₂-agonist; VHC, valved holding chamber.

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Developed by the New York State Consensus Asthma Guideline Expert Panel, and endorsed by the New York State Department of Health, New York City Department of Health and Mental Hygiene, New York Heath Plan Association, New York State Coalition of Prepaid Health Services Plans, Empire Blue Cross Blue Shield, Excellus, Medical Society of the State of New York, New York State Academy of Family Physicians, New York Chapter American College of Physicians, American Academy of Pediatrics, District II, New York State Thoracic Society, American Lung Association of New York, the New York State Society of Allergy, Asthma & Immunology, Inc., and Monroe County Medical Society.

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