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ROC Breathes Easy
Asthma Initiative

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ROC Breathes Easy Asthma Initiative

Community Guidance

Relief + Control = One Combination Inhaler

Updated 1/2026

Relief + Control = One Combination Inhaler for the Win!

Short-Acting Beta-Agonist (SABA) Stewardship:[1]

- **Address SABA over-reliance leading to associated harms.**
- **Recognize the need to move away from episodic symptom relief with acute management and to embrace a chronic disease model.**

SABA reliever monotherapy (albuterol by itself) does not address underlying airway inflammation and should be avoided for the majority of patients with asthma.[2]

Numerous studies show that over-reliance on SABA is associated with increased morbidity and mortality due to asthma, particularly in our most vulnerable patients.[3,4,5] Chronic airway inflammation, a defining characteristic of asthma, is the underlying etiology leading to asthma symptoms, exacerbations requiring systemic steroids, and impaired lung function. Underlying airway inflammation should not be left untreated for any patient with asthma,[6] and most children with asthma should initiate treatment with an inhaled preventive medication at the time of initial asthma diagnosis. **All patients, regardless of race/ethnicity, should have their treatment optimized, with the goal of being symptom-free.**

For children 6 years of age and older with symptomatic asthma, a single combination inhaler (consisting of an anti-inflammatory inhaled corticosteroid and reliever medication) should be considered as first-line therapy for both rescue and prevention. Studies show that this approach decreases exacerbation risk while minimizing use of medication.[7,8]

For children 6 years of age and older who are symptomatic, the familiar two-inhaler management approach [SABA reliever monotherapy and a separate anti-inflammatory controller] should be avoided, when possible. Children under the age of 6 may utilize an inhaled corticosteroid in conjunction with a separate SABA reliever medication.[9]

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Oral Corticosteroid (OCS) or Systemic Steroid Stewardship:[10,11]

- **It is time to protect patients with asthma from potential overexposure to oral corticosteroids (OCS) and to recognize OCS overuse for what it often is: a treatment plan failure.**
- **OCS use is a signal that a patient may need an updated treatment plan or support with adherence concerns.**
- **OCS or systemic steroid use should not be confused with inhaled corticosteroids (ICS), which have fewer risks.**

OCS/Systemic Steroid Health Risks:[10,12,13,14]	
Short Term	**Long Term**
○ Problems with mood, stress, memory and behavior ○ Sleep disturbance ○ Weight gain ○ Hyperglycemia ○ Gastroesophageal reflux ○ Thromboembolism ○ Infection / Increased risk for Sepsis	○ Growth suppression ○ Increase risk of diabetes ○ Glaucoma/Cataracts ○ Hypertension ○ Adrenal Suppression ○ Osteoporosis ○ Dyslipidemia ○ Immunosuppression

Collaborative Recommendations to Curb Overexposure:

1. Educating patients and their caregivers about (1) the risks associated with OCS; (2) the importance of adherence to other asthma medicines; and (3) advanced treatment options. (4) discuss the importance of completing the full prescribed OCS course when appropriate and necessary.
2. Supporting healthcare providers (allergists, pulmonologists, and primary care) to develop and adopt OCS–sparing strategies and practice shared decision-making.
3. Petitioning payers to adopt OCS-sparing strategies by providing appropriate and timely access to conventional and advanced treatment options based on clinical judgement of the treating HCP in consultation with the patient.

ROC Breathes Easy Asthma Initiative

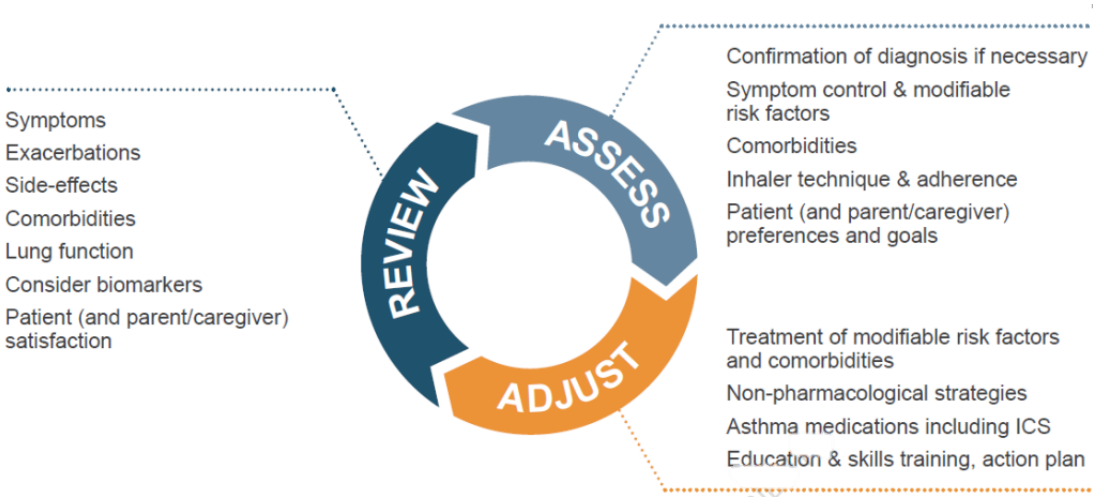
Community Guidance

Updated 1/2026

Management Pathway for ALL Patients with Asthma ≥ 6 Years
Transition to Single Inhaler Management Upon Earliest Opportunity to Treat

Adapted from 2025 GINA Guidelines

Asthma treatment is not 'set and forget', and not just medications



1. Primary Care Asthma Follow-Up for ≥ 6 Years of Age:

Confirm Asthma Diagnosis [*when necessary and/or if possible*]

- **Children ≥ 6 years of age should strongly be considered for lung function testing (spirometry, exhaled nitric oxide) as objective measures of asthma have been shown to increase diagnostic accuracy.**

Include Routine Impairment/Risk Assessment during Visits with the Patient OR as Pre-Visit Screening Tool

[Includes Post-Exacerbation Recovery Evaluation, when needed]

How Are Asthma Symptoms? Please select YES or NO for each question.		Well Controlled	Partly Controlled	Uncontrolled
IMPAIRMENT/SYMPTOMS In the past 4 WEEKS, have you/your child had:		NONE of these	1-2 of these	3-5 of these
DAYTIME asthma symptoms (cough, wheeze, chest tightness, or shortness of breath) more than twice a week?	Yes ☐ No☐	No change or consider step down; may lower daily ICS dose, but caution with stopping ICS altogether	Consider stepping up, after review and assess*	Consider stepping up [1-2 steps], after review and assess*
ANY night WAKING due to asthma?	Yes ☐ No☐			
SABA# reliever NEEDED for symptoms more than twice a week?	Yes ☐ No☐			
ANY activity LIMITATION due to asthma?	Yes ☐ No☐			
RISK In the past YEAR, have you/your child had:				
ANY flare-up or exacerbation requiring oral/systemic steroids, ED visit, OR hospitalization?	Yes ☐ No☐			

***BEFORE stepping-up**, **REVIEW** inhaler (spacer) **TECHNIQUE** and **ADHERENCE**. **CONFIRM** diagnosis.
ASSESS: Modifiable risk factors and comorbidities. **SHARED** decision-making regarding **PREFERENCES/GOALS.**

#Only for patients using SABA reliever (not ICS-formoterol reliever). Do not include SABA taken before exercise.

ROC Breathes Easy Asthma Initiative

Community Guidance

Updated 1/2026

Management Pathway for ALL Patients with Asthma ≥ 6 Years
Transition to Single Inhaler Management Upon Earliest Opportunity to Treat

Adapted from 2025 GINA Guidelines

1a. Urgent Care/ED/Acute Encounter for Exacerbation/Flare-up for ≥ 6 Years of Age:

[POSSIBLE INITIAL TOUCHPOINT: May occur BEFORE Primary Care Asthma Follow-Up]

May require treatment with nebulized albuterol, OCS, etc. in acute setting

Treatment (minimum) Before Acute Discharge:

- **REPLACE SABA with PRN Anti-Inflammatory Reliever (AIR) therapy**, a reliever inhaler that contains both a low-dose ICS and a rapid-onset long-acting bronchodilator **(see Appendix for prescribing examples)**
  - **Prescribe/Refill PRN ICS-formoterol** [**Symbicort®** or **Breyna®**], **dosing as below**
  - **ICS-formoterol also taken every 12 hours post-exacerbation until primary care follow-up occurs.**
    - **Daily Dose Maximum:**
      - **Children 6-11 years: 8 puffs/24 hours with 80/4.5 mcg budesonide-formoterol**
      - **≥ 12 years: 12 puffs/24 hours with 160/4.5 mcg budesonide-formoterol**
- **Prescribe/dispense spacer/holding chamber**
- **Follow-Up Plan [from Acute Care Setting]:**
  - **Schedule a post-exacerbation follow-up and preventive asthma care review/update appointment for within 1-2 working days (children) and within 2-7 days (adults), whenever possible**

**Currently working with insurance to improve availability/dose and quantity limits. This may require a prior authorization or review of plan's formulary.*

2. RISK Factor Screen/Assessment [Required Post-Exacerbation] for ≥ 6 Years of Age:

Document Aspects of Future Risk, Include Modifiable Factors to Guide Preventive Interventions and Management

- **Factors [examples] that increase RISK of exacerbations even if patient has FEW asthma symptoms:**
  - **SABA over-use:** ≥3 x 200 dose canisters/year; ≥1 canister/month
  - **Inadequate ICS:** No ICS: poor adherence/inhaler technique
  - **Environmental exposures:** Smoke; air pollution; allergens (if sensitized)
  - **Poverty status:** Economic instability; public (or no) health insurance; substandard housing
  - **Exacerbation history:** Severe flare-up in prior 12 months; ever intubated or in ICU for asthma
- **Address MODIFIABLE Factors** [include/document steps taken]
- **Assess and Manage Comorbidities**
- **Consider Referral to an Asthma Specialist**

3. Preventive Asthma Care Review: Update/Adjust Management Plan for ≥ 6 Years of Age:

- **For ALL Patients with RISK OR requiring STEP 3 or 4 care:**
  - **Strongly consider updating management to (Single) Maintenance And Reliever Therapy [(S)MART] approach**
  - **Recommend referral to an Asthma Specialist**
- **For ALL others (those Well Controlled[6] AND NOT at RISK), consider transition to Single Inhaler PRN Anti-Inflammatory Reliever [AIR] therapy [see Appendix for prescribing examples and 1a. Acute Encounter for Exacerbation, above]**
- **Discontinue PRN SABA [albuterol] whenever possible for patients transitioned to AIR or (S)MART approach**
- **Update Asthma Action Plan for distribution to patient/family/school and/or daycare.**

Appendix: GINA References[6] and Supporting Materials for ≥6 Years of Age

Examples of (S)MART and AIR Recommended Products

Age	Inhaled Medication Unit Dose	Step (Dose)	Schedule and Frequency	Maximum Daily Dose#
6-11 years	budesonide-formoterol 80/4.5 mcg [Symbicort® HFA or Breyna® HFA]	Step 3 (Low)	(S)MART: 1 inhalation ONCE daily plus 1 as needed	8 inhalations in 24 hours
		Step 4 (Medium)	(S)MART: 1 inhalation TWICE daily plus 1 as needed	
≥ 12 years	budesonide-formoterol 160/4.5 mcg [Symbicort® HFA or Breyna® HFA]	Steps 1-2	AIR-only: 1 inhalation as needed	12 inhalations in 24 hours
		Step 3 (Low)	(S)MART: 1 inhalation TWICE (or ONCE) daily plus 1 as needed	
		Steps 4-5 (Medium)	(S)MART: 2 inhalations TWICE daily plus 1 as needed	
≥ 18 years	mometasone-formoterol 100/5 mcg [Dulera® HFA]	Steps 1-2	AIR-only: 1 inhalation as needed	12 inhalations in 24 hours
		Step 3 (Low)	(S)MART: 1 inhalation TWICE (or ONCE) daily plus 1 as needed	
		Steps 4-5 (Medium)	(S)MART: 2 inhalations TWICE daily plus 1 as needed	

Example Prescription Language[6]

Example (S)MART budesonide-formoterol medication prescription language:

For ≥ 12 years: [**budesonide-formoterol 160/4.5 mcg**] "Inhale 1 puff using spacer TWICE daily [MORNING and EVENING]; May also inhale 1 puff as NEEDED for symptom relief [Maximum: 12 puffs/24hrs]; Shake well before, rinse mouth after use"

For 6-11 years: [**budesonide-formoterol 80/4.5 mcg**] "Inhale 1 puff using spacer TWICE daily [MORNING and EVENING]; May also inhale 1 puff as NEEDED for symptom relief [Maximum: 8 puffs/24hrs]; Shake well before, rinse mouth after use"

Notes to pharmacy:

- "Initial TWO inhalers for 30 DAY supply, home/school daily+PRN use. Symbicort or Breyna per insurance. (S)MART per GINA, **https://bit.ly/4pQQpvk**"
- "For REFILLS, home/school daily+PRN use. Symbicort or Breyna per insurance. (S)MART per GINA, **https://bit.ly/4pQQpvk**"

Example PRN Anti-Inflammatory Reliever [AIR] therapy (ICS-formoterol) prescription language:

For ≥ 12 years: [**budesonide-formoterol 160/4.5 mcg**] "Inhale 1 puff using spacer as NEEDED for symptom relief [Maximum: 12 puffs/24hrs]; Shake well before, rinse mouth after use"

Example School Medication Order Language:[15]

PRN component of (S)MART approach or PRN Anti-Inflammatory Reliever [AIR] therapy (same for both) with budesonide-formoterol:

For ≥ 12 years: [**budesonide-formoterol 160/4.5 mcg**] "Inhale 1 puff using spacer as NEEDED for persistent symptoms, may administer up to 2 inhalations every 20 minutes for 3 doses, the need for more frequent dosing suggest an incomplete response and may require further medical attention, [Maximum: 12 puffs/24hrs]; Shake well before, rinse mouth after use"

PRN component of (S)MART approach with budesonide-formoterol:

For 6-11 years: [**budesonide-formoterol 80/4.5 mcg**] "Inhale 1 puff using spacer as NEEDED for persistent symptoms, may administer up to 2 inhalations every 20 minutes for 3 doses, the need for more frequent dosing suggest an incomplete response and may require further medical attention, [Maximum: 8 puffs/24hrs]; Shake well before, rinse mouth after use"

Select References:

NAEPP 2020 Focused Updates to the Asthma Management Guidelines
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