

**Derbyshire Medicines Management, Prescribing and Guidelines**  
**DERBYSHIRE PRIMARY CARE FORMULARY**

**Chapter 3: RESPIRATORY SYSTEM**

**Updated: March 2025**

The following prescribing guidelines are relevant to the respiratory chapter and can be found [here](#)

- Children's referral guideline for SLIT- Grazax and Acarizax (Derby Children's Hospital)
- Anaphylaxis treatment for adults and children
- Asthma management in adults/ Asthma management in children
- Chronic Obstructive Pulmonary Disease guideline
- Greener Inhaler Prescribing guidance
- Oxygen guideline

Relevant Resources

- COPD detailing aid
- Greener inhaler choice: Flowchart/ Be Greener and Breathe Better patient information leaflet
- Stepping-down combination asthma inhaler therapy: Adults over 17 years of age
- Optimisation of inhaled corticosteroid (ICS) in COPD
- Adult Asthma Diagnosis Algorithm – [North Derbyshire](#), [South Derbyshire](#)
- Respiratory action plans - [Asthma & Lung UK](#)
- [RightBreathe](#) – inhaler information/training videos
- [Inhaled corticosteroid equivalent doses](#)

**Reducing the carbon impact of inhalers**

Metered dose inhalers (MDIs), also known as pressurised metered dose inhalers (pMDIs), including breath-actuated MDIs, contain propellants known as hydrofluorocarbons (HFCs) which are powerful greenhouse gases and can contribute to global warming. Dry powder inhalers (DPIs) and soft mist inhalers (SMIs) such as Respimat do not contain propellant, so they have a lower carbon footprint than other inhalers.

NHS Derby and Derbyshire ICB/System partners support the prescribing of inhalers with a reduced carbon footprint such as DPIs and SMIs, wherever clinically appropriate and acceptable to the patient, in accordance with [NHS targets](#). Medication reviews, Structured Medication Reviews or planned Asthma Reviews taking place in primary care should consider moving or facilitating patients to lower carbon options where it is clinically appropriate to do so. See [Greener inhaler prescribing guidance](#).

All formulary dry powder inhalers contain lactose and are contraindicated in patients with IgE mediated hypersensitivity to lactose or milk proteins. Refer to The SPC for full prescribing information

[MHRA July 2018](#) Pressurised metered dose inhalers (pMDIs): risk of airway obstruction from aspiration of loose objects. Remind patients to check and remove the mouthpiece cover properly before inhaling a dose and to shake the inhaler to remove loose objects that may have become trapped in the inhaler during storage.

**3.1 Bronchodilators**

**3.1.1 Adrenoreceptor agonists**

Short acting beta agonist (SABA)	Traffic Light Classification	Licensed	Additional information
<b>Salbutamol preparation</b>			
• 100 micrograms CFC Free inhaler (MDI) ( <b>Salamol</b> )	<b>GREEN</b>	Adults and children ≥4 years of age	The metered dose inhaler (MDI) is usually the most cost-effective delivery device for salbutamol and should be considered for those patients requiring a SABA and as a matter of routine for all paediatric patients. Salamol MDI is the preferred choice salbutamol inhaler due to lower carbon footprint compared to other salbutamol MDIs. Patients who are unable to use a standard salbutamol MDI may find a dry powder device or breath-actuated inhaler more acceptable. The brand must be
• 100 micrograms salbutamol Easyhaler (DPI)	<b>GREEN</b>		
• 200micrograms Ventolin Accuhaler (DPI)	<b>GREEN</b>		
• 100 microgram Breath-actuated CFC free inhaler (MDI) ( <b>Salamol</b> )	<b>GREEN</b>		

<ul style="list-style-type: none"> <li>Nebuliser solution 2.5mg/2.5ml</li> </ul>			specified to avoid confusion with these devices. Nebulised bronchodilators should not be prescribed unless a formal nebuliser assessment has been carried out. Do not use 5mg salbutamol nebulisers for COPD, as evidence does not support doses above 2.5mg. Nebulisers should be used with extreme caution in children and only under the care of a respiratory paediatrician ( <a href="#">MHRA Aug 2022</a> ).
Long-acting beta agonist (LABA)	Traffic Light Classification	Licensed	Additional information
<b>Formoterol preparations</b> <ul style="list-style-type: none"> <li>12 micrograms Easyhaler (DPI)</li> <li>12 micrograms CFC free inhaler (MDI) (Atimos Modulite)</li> </ul>	<b>GREEN</b>  <b>GREEN</b>	Adults and children ≥6 years of age  Adults and children ≥12 years of age	First-line LABA  Alternative first-line LABA for patients requiring an MDI
<b>Salmeterol preparations</b> <ul style="list-style-type: none"> <li>25 micrograms CFC Free inhaler (MDI) (Soltel)</li> </ul>	<b>GREEN</b> 2 <sup>nd</sup> line LABA	Soltel - Adults and children >12 years of age Serevent - Adults and children ≥4 years of age	<b>Soltel</b> is currently the formulary choice N.B. All brands apart from Serevent contain soya lecithin – <b>contra-indicated in peanut or soya allergy</b> . If the patient has a soya or peanut allergy, then prescribe as the brand Serevent

### 3.1.2 Antimuscarinic bronchodilators

Short acting antimuscarinic bronchodilators (SAMA)	Traffic Light Classification	Licensed	Additional information
<b>Ipratropium</b> <ul style="list-style-type: none"> <li>20 microgram inhaler CFC free (MDI)</li> </ul>	<b>GREEN</b>	COPD and asthma Adults and children (including those <6 years of age)	Asthma – MDI is not recommended by SIGN/BTS or NICE for routine asthma management. Nebulised solution may be used as an add-on treatment for a severe asthma attack.

- Ipratropium nebuliser solution for COPD should only be used in severe COPD patients [FEV1<30%] after initiation by a specialist.
- Long acting muscarinic antagonist (LAMA) monotherapy is no longer recommended first line in the management of COPD- see [local guidance](#). When initiating a LAMA, take care to ensure the SAMA is stopped. All the single component LAMAs are available in combined LABA/LAMA inhalers but some patients may need a single component LAMA therapy or may not wish to switch.
- Tiotropium (**GREY**) is the preferred LAMA for existing stable patients on single component LAMA treatment.

Long-acting muscarinic antagonists (LAMA)	Licensed	Traffic Light Classification	Additional Information
Tiotropium  (Preferred LAMA for existing stable patients on single component LAMA treatment.)	COPD	<b>GREY</b>	18 microgram inhalation powder (DPI): Advise patients to NEVER insert the capsule directly into the mouthpiece, follow instructions provided with the inhaler.  Trokide is the most cost effective brand. Trokide inhaler device should be replaced every 3 months.  Tiogiva inhaler device should be replaced every 6 months.

	Asthma	GREY after consultant/specialist initiation	2.5microgram inhalation solution cartridge CFC free (soft mist inhaler) (Spiriva Respimat):  Respimat inhaler is a re-usable device with cartridge. Each re-usable inhaler may be used with up to six cartridges.
Glycopyrronium	COPD	GREY 2 <sup>nd</sup> line LAMA	Seebri Breezhaler: In patients with severe renal impairment (eGFR below 30mL/min/1.73m <sup>2</sup> ), including those with end-stage renal disease requiring dialysis. These patients should be monitored closely for potential adverse reactions.
Umeclidinium	COPD	GREY 2 <sup>nd</sup> line	ONCE daily
Acclidinium	COPD	GREY 3 <sup>rd</sup> line	TWICE daily  Each delivered dose contains 375mcg of acclidinium bromide, equivalent to 322mcg.

[MHRA Feb 2015](#) prescribers should take the risk of cardiovascular side effects into account when prescribing inhaled tiotropium to patients with certain cardiac conditions, who were excluded from clinical trials of tiotropium. This also applies to all LAMAs (See individual SPCs for further details detail).

#### Combination inhalers N.B. Prescribe by brand

LABA/LAMA combinations	Traffic Light Classification	Licenced	Dosing	Additional information
<b>Tiotropium and olodaterol (Spiolto Respimat) (SMI)</b>	<b>GREEN</b> 1 <sup>st</sup> line LABA /LAMA	COPD	OD	Respimat inhalers are re-usable device with cartridge. Each re-usable inhaler may be used with up to six cartridges.  Choice should be based on patient tolerance, ease of use, and environmental impact of the inhaler device.  LABA/LAMA combination inhaler is recommended for COPD patients who remain breathless or have exacerbations despite SABA or SAMA treatment and present with no asthmatic features or features suggestive of steroid responsiveness.
<b>Glycopyrronium and Indacaterol (Ultibro Breezhaler) (DPI)</b>	<b>GREEN</b> 1 <sup>st</sup> line LABA /LAMA	COPD	OD	
<b>Umeclidinium and vilanterol (Anoro Ellipta) (DPI)</b>	<b>GREEN</b> 1 <sup>st</sup> line LABA /LAMA	COPD	OD	
<b>Acclidinium and formoterol (Duaklir Genuair) (DPI)</b>	<b>GREEN</b> 1 <sup>st</sup> line LABA /LAMA	COPD	BD	
<b>Glycopyrronium + formoterol (Bevespi Aerosphere) (MDI)</b>	<b>GREEN</b> 1 <sup>st</sup> line LABA/LAMA for patient requiring an MDI	COPD	BD	

1. Roflumilast is **GREY**- specialist initiation. Roflumilast is a phosphodiesterase type-4 inhibitor with anti-inflammatory properties. It is used as an add-on to bronchodilator therapy in adults with severe COPD with chronic bronchitis as per [NICE TA461](#). Ongoing GP prescribing and care of patients on roflumilast should only be considered if patient is stable and free from adverse reactions, after a minimum of 3 months roflumilast treatment under the respiratory specialist. For more details see local [COPD guideline](#).

### 3.1.3 Theophylline

**Theophylline SR tablets** (Uniphyllin Continus) 200mg, 300mg, 400mg

1. Common interactions for theophylline which increase clearance and it may therefore be necessary to increase dosage to ensure therapeutic effect include barbiturates, carbamazepine, lithium, phenytoin, rifampicin, primidone, ritonavir. (See SPC for full details)  
The following reduce clearance, and a reduced dosage may therefore be necessary to avoid side-effects: allopurinol, cimetidine, macrolide antibiotics (e.g., erythromycin), furosemide, and oral contraceptives. (See SPC for full details)
2. Smoking can increase theophylline clearance and increased doses of theophylline are therefore required; dose adjustments are likely to be necessary if smoking started or stopped during treatment.
3. Plasma-theophylline concentration is increased in heart failure, hepatic impairment, and in viral infections. Plasma-theophylline concentration is decreased in smokers and by alcohol consumption. Differences in the half-life of theophylline are important because the toxic dose is close to the therapeutic dose.
4. See [SPS](#) for monitoring information.

### 3.1.5 Peak flow meters, inhaler devices and nebulisers

Appropriate peak flow meter

Appropriate spacer device

**EasyChamber Spacer  
Volumatic**

See **Right Breathe** [website](#) for information on spacer compatibility.

1. Standard-range peak flow meters are suitable for both adults and children; low-range peak flow meters are appropriate for severely restricted airflow in adults and children.
  - a. Standard = 60-800L/minute
  - b. Low = 30-400L/minute
2. EasyChamber fits most MDIs and is compatible with formulary choices although may not be licensed, refer to Right Breathe's website for more information.
3. Follow usage and cleaning instructions supplied with the spacer. Spacer devices should be allowed to air dry to prevent the build-up of static which can alter airflow. Most spacers should be replaced every 12 months and may be recyclable, however this varies from brand to brand. See Right Breathe for further information.  
[Drug Safety Update](#), July 2008 **Spacers should not be regarded as interchangeable** – patients whose asthma is well-controlled and who are using a spacer should always use the same type of spacer and not switch between spacers. Different spacers may deliver different amounts of inhaled corticosteroid, which may have implications for both safety and efficacy.
4. All patients with an acute asthma attack at home, and symptoms not controlled by the maximum daily licensed dose of anti-inflammatory reliever (AIR) therapy or maintenance and reliever therapy (MART) or up to 10 puffs of salbutamol via a pMDI and spacer, should seek urgent medical attention. (BTS/SIGN/[NICE Jan 2025](#)).
5. [MHRA Aug 2022](#) : home use of nebulisers in paediatric asthma should be initiated and managed only by specialists (under a treatment plan). Use of a nebuliser purchased independently of medical advice for use in the home to deliver nebulised asthma rescue medications to children can mask a deterioration in the underlying disease and may increase the risk of potentially fatal delays in seeking medical attention if asthma deteriorates.

## 3.2 Inhaled Corticosteroids

**N.B. Prescribe by brand**; Use spacer device with MDI for all doses of inhaled corticosteroid.

See [adults](#) and [children's](#) asthma guidance for inhaled corticosteroid doses

Corticosteroids (ICS)	Licenced	Traffic Light Classification	Additional information
<b>Beclometasone dipropionate</b> <ul style="list-style-type: none"> <li>• <b>Soprobe</b> MDI 50, 100, 200, 250 micrograms</li> <li>• <b>Kelhale</b> MDI 50,100 micrograms (extra fine particles)</li> <li>• <b>QVAR</b> MDI 50, 100 micrograms(extra fine particles)</li> </ul>	<p>Asthma- adults and children (only 50 &amp; 100 microgram inhalers are licensed for children &amp; adolescents)</p> <p>Asthma- adults &gt;18 years</p> <p>Asthma- ≥5 years of age</p>	<p><b>GREEN</b></p> <p><b>GREEN</b></p> <p><b>GREEN</b></p>	<p>Soprobe is therapeutically equivalent to Clenil.</p> <p>Kelhale is therapeutically equivalent to Qvar.</p> <p>Kelhale/Qvar twice as potent as Soprobe (e.g. Kelhale/Qvar 50 micrograms is equivalent to Soprobe100micrograms)</p>
<b>Budesonide</b> <ul style="list-style-type: none"> <li>• <b>Easyhaler</b> (DPI) 100, 200,400</li> </ul>	Asthma- ≥6 years of age	<b>GREEN</b>	<i>dose equivalent to standard particle beclomethasone (Soprobe/ Clenil)</i>
<b>Fluticasone propionate</b> <ul style="list-style-type: none"> <li>• <b>Flixotide Accuhaler</b> (DPI)100 microgram</li> <li>• <b>Flixotide Evohaler</b> (MDI) 50 microgram</li> </ul>	Asthma- >4 years of age	<p><b>GREEN</b> for children</p> <p><b>GREY</b> for adults</p>	<p>As per <a href="#">children's</a> asthma guidance</p> <p>Fluticasone is twice as potent as Soprobe/Clenil (e.g. fluticasone 50 microgram is equivalent to Soprobe100micrograms)</p> <p>All other formulations of fluticasone propionate are classified as <b>GREY</b> on the formulary.</p>

**Combination inhalers N.B.** Prescribe by brand. See asthma and COPD [guideline](#) and [Inhaled corticosteroid equivalent doses](#).

LABA/ICS combination	Licenced	Traffic Light Classification	Additional information
<b>Budesonide and formoterol</b> <ul style="list-style-type: none"> <li>• <b>Fobumix easyhaler</b> DPI 80/4.5,</li> <li>• <b>Fobumix easyhaler</b> DPI 160/4.5, 320/9</li> <li>• <b>WockAIR</b> DPI 160/4.5, 320/9</li> <li>• <b>DuoResp Spiromax</b> DPI 160/4.5, 320/9</li> <li>• <b>Symbicort Turbohaler</b> DPI 100/6 Symbicort Turbohaler DPI 200/6, 400/12</li> <li>• <b>Symbicort</b> MDI 200/6</li> </ul>	<p>Asthma (≥6 years of age)</p> <p>Asthma (≥12 years of age) &amp; COPD</p> <p>Asthma (≥12 years of age) &amp; COPD</p> <p>Asthma (≥12 years of age) &amp; COPD</p> <p>Asthma (≥6 years of age) Asthma (≥12 years of age) &amp; COPD</p> <p>COPD</p>	<p><b>GREEN</b> 1<sup>st</sup> line LABA/ICS combination inhaler</p> <p><b>GREEN</b> 1<sup>st</sup> line LABA/ICS combination inhaler</p> <p><b>GREEN</b></p> <p><b>GREEN</b></p> <p><b>GREEN</b></p> <p><b>GREEN</b></p> <p><b>GREY</b></p>	<p>Fobumix 80/4.5, 160/4.5, 320/9 is equivalent to Symbicort 100/6, 200/6, 400/12 respectively Fobumix 80/4.5 licensed for asthma only.</p> <p>WockAIR is the most cost effective DPI where appropriate but is only available in two strengths</p> <p>WockAIR and DuoResp 160/4.5, 320/9 is equivalent to Symbicort 200/6, 400/12 respectively.</p> <p>Symbicort pMDI contains propellant HFA227ea which has a significantly higher carbon footprint than other propellants and so should be avoided where possible.</p>
<b>Beclometasone (extra fine) and formoterol</b> <ul style="list-style-type: none"> <li>• <b>Fostair Nexthaler</b> DPI 100/6</li> <li>• <b>Fostair Nexthaler</b> DPI 200/6</li> </ul>	Asthma (≥18 years of age) & COPD	<b>GREEN</b>	

<ul style="list-style-type: none"> <li>Proxor, Bibecfo, Luforbec MDI 100/6</li> <li>Proxor, Bibecfo, Luforbec MDI 200/6</li> </ul>	<p>Asthma (≥18 years of age)</p> <p>Asthma (≥18 years of age) &amp; COPD</p>	<p><b>GREEN</b> 1<sup>st</sup> line for patients requiring an MDI</p>	<p>100 micrograms of beclometasone dipropionate via Proxor/Luforbec/Bibecfo/Fostair products are equivalent to 250 micrograms of beclometasone dipropionate in standard particle CFC-free inhalers.</p>
<p><b>Fluticasone propionate and salmeterol</b></p> <ul style="list-style-type: none"> <li>Combisal MDI 50/25</li> <li>Seretide MDI 50</li> <li>Seretide Accuhaler DPI 100</li> <li>Fixkoh Airmaster DPI 50/100</li> </ul> <ul style="list-style-type: none"> <li>Combisal MDI 125/25, 250/25</li> <li>Fixkoh DPI 500/50</li> <li>Fusacomb Easyhaler DPI 500/50</li> </ul>	<p>Asthma ≥4 years of age Asthma ≥12 years of age</p> <p>Asthma ≥12 years of age</p> <p>Asthma &gt;12 years of age &amp; COPD</p> <p>Asthma (≥12 years of age) &amp; COPD</p>	<p><b>GREEN</b> for children <b>GREY</b> for adults</p> <p><b>GREY</b> - limited place of therapy for adults</p>	<p>See children's asthma <a href="#">guidance</a>.</p> <p>Combisal MDI is the cost-effective alternative for Seretide evohaler. Children receiving Seretide/Combisal 50 MDI or Seretide/ Fixkoh 100 Accuhaler should be reviewed at age 18 year and considered for the formulary choice ICS/LABA combination inhalers.</p> <p>Fluticasone/salmeterol combination has limited place of therapy in adults- following choices in local COPD guidance only. Fixkoh DPI/Fusacomb Easyhaler are cost-effective alternative for Seretide Accuhaler 500</p>
<p><b>Triple combination (ICS+ LABA+ LAMA)</b></p>	<p><b>Licensed</b></p>	<p><b>Traffic Light Classification</b></p>	<p><b>Additional information</b></p>
<p><b>Fluticasone, vilanterol and umeclidinium (Trelegy) (DPI)</b></p> <p><b>Beclometasone, formoterol and glycopyrronium (Trimbow NEXThaler DPI)</b></p> <p><b>Beclometasone, formoterol and glycopyrronium (Trimbow) (MDI)</b></p> <p><b>Budesonide, formoterol and glycopyrronium (Trixeo aerosphere) (MDI)</b></p> <p><b>Mometasone, indacaterol and glycopyrronium (Energair Breezhaler) (DPI)</b></p>	<p>COPD</p> <p>COPD</p> <p>COPD Asthma in adults (172/5/9 microg licensed for asthma only)</p> <p>COPD</p> <p>Asthma in adults</p>	<p><b>GREY</b> 1<sup>st</sup> line triple combination</p> <p><b>GREY</b> 1<sup>st</sup> line triple combination</p> <p><b>GREY after consultant/ specialist initiation for asthma.</b></p> <p><b>GREY</b></p> <p><b>GREY after consultant/ specialist initiation for asthma.</b></p>	<p>Indicated for the maintenance treatment of moderate to severe COPD.</p> <p>Triple therapy is reserved for exceptional use in severe disease in the presence of persistent exacerbations or patient is still limited by symptoms despite other treatments.</p> <p>Triple therapy in a single inhaler may be preferable for people who have difficulty using more than one device or who find their medication regimen difficult or confusing and have trouble complying with treatment. However triple therapy lack flexibility and makes it difficult to amend the individual medicines if treatment needs changing for any reason.</p> <p>Use of combination product can be more cost effective than using the separate components.</p> <p>Energair Breezhaler and Trimbow MDI are licensed for asthma in adults not adequately controlled with a maintenance combination of a LABA+ ICS who experienced one or more asthma exacerbations in the previous year. Locally this is classified as specialist initiation only.</p>

- All doses of inhaled steroid delivered via an MDI should be via a spacer device. This form of administration improves delivery of drug to the airways reducing local effects e.g., oral candida and also reduces deposition in the oropharynx (thereby reducing local adverse effects and the amount of systemic absorption).
- SIDE EFFECTS:** Inhaled steroids do not usually cause adrenocortical suppression at normal doses (up to about 1500 micrograms/day of beclometasone (standard particle size)). Oral candidiasis may be related to dose and dose frequency. Patients should be advised to rinse the mouth after use of high

dose steroids to help minimize this. Dysphonia can occur. The use of a large volume spacer device (Volumatic) may reduce these local adverse effects.

3. Inhaled corticosteroids and adrenal suppression in children – ‘Adrenal suppression may be under-recognised’. Prescribers are reminded that:
  - It is important to monitor therapy regularly and titrate down to the lowest dose at which effective control of asthma is maintained.
  - Growth (height and weight centile) should be monitored at least annually in children with asthma.
  - In paediatric practice adrenal suppression has been seen at doses as low as 800 micrograms/day (standard particle size). All children on these doses should have careful growth monitoring and a written management plan advising about the risk of adrenal suppression.
4. If a doctor considers that a child’s asthma is not controlled despite an increase to a high dose of inhaled corticosteroid plus a LABA, the child should be referred to a specialist in the management of paediatric asthma.
5. National patient safety alert [August 2020](#) - steroid emergency card to be issued by prescribers to help healthcare staff to identify appropriate patients and gives information on the emergency treatment if they are acutely ill, or experience trauma, surgery or other major stressors. For further guidance on this see [when should I issue a steroid emergency alert card](#). Patients on high dose ICS (>1000 microgram BDP equivalent/day) should be advised to carry a blue steroid treatment card.
6. [MHRA, 2017](#). Advise patients to report any blurred vision or other visual disturbances due to rare risk of central serous chorioretinopathy with corticosteroids.
7. The role of Maintenance and reliever therapy (MART) has a limited place for patient therapy and selection. MART is suitable for patients who despite good adherence to regular maintenance doses of a combination ICS/LABA inhaler, have;
  1. Inadequate asthma control and are in frequent need of reliever medication.
  2. Asthma exacerbations in the past requiring medical intervention.
8. **Inhaled Budesonide for treatment of COVID-19-** Inhaled budesonide should no longer be considered as a treatment for individuals with COVID-19 infection other than within the context of a clinical trial. People already using budesonide for conditions other than COVID-19 should continue treatment if they test positive for COVID-19. See NICE [NG191 Covid-19 rapid guideline: managing COVID-19](#) (updated May 2024)

### 3.3.2 Leukotriene receptor antagonists

See *adult and children’s asthma guidance*

**Montelukast** tabs 10mg, chewable tabs 4mg, 5mg, granules 4mg

1. Granules are more expensive and should be reserved for children between 6 months and 2 years old or if chewable tablets not suitable. 4mg chewable tablets are licensed in children 2-5 years old; 5mg chewable tablets are licensed in children 6-14 years old; 10mg tablets licensed for adults and children 15 years and over
2. [MHRA April 2024](#) Montelukast: risk of neuropsychiatric reactions
  - be alert for neuropsychiatric reactions in patients taking montelukast; events have been reported in adults, adolescents, and children
  - discontinue montelukast if patients experience new or worsening symptoms of neuropsychiatric reactions
  - advise patients and their caregivers to carefully read the list of neuropsychiatric reactions in the Patient Information Leaflet and to seek medical advice immediately should they occur.
  - Patients, parents and carers should be warned of possible adverse reactions affecting sleep, behaviour and mood.

### 3.4.1 Antihistamines

For treatments of minor self-limiting conditions such as mild to moderate hay fever, [self-care](#) is encouraged. Treatments are available to purchase over-the-counter.

**Cetirizine** 10mg tabs

*Non-sedating*

**Loratadine** 10mg tabs, oral solution 5mg/5ml

*Non-sedating*

**Chlorphenamine** tabs 4mg, oral solution 2mg/5ml

*Sedating*

1. JAPC has classified alimemazine as **Do Not Prescribe (DNP)** due to lack of cost-effectiveness. Suitable alternative that may be considered is promethazine (**GREY**).

### 3.4.2 Allergen immunotherapy

1. Omalizumab (NICE TA278) for allergic asthma is **RED**
2. Mepolizumab (NICE TA671) for eosinophilic asthma is **RED**

### 3.4.3 Allergic emergencies

**Jext** auto-injector 150 micrograms, 300 micrograms [PIL](#)

**EpiPen** auto-injector 0.3mg, **EpiPen Jr** auto-injector 0.15mg [PIL](#) /[EpiPen Jnr PIL](#)

1. [MHRA June 2023](#)- Adrenaline auto-injectors (AAIs): new [guidance](#) and resources for safe use- including an easy step-by-step guide on what to do in an emergency and updated advice on body positioning. A toolkit of resources is available for health and social care professionals to support the safe and effective use of AAIs. Use the materials to inform patients and caregivers what to do if they suspect anaphylaxis and how to use adrenaline auto-injectors (AAIs)
2. [MHRA 2017](#) recommends two adrenaline auto-injectors should be prescribed which patients should carry at all times.
3. Adrenaline has a narrow therapeutic index. Primary care clinicians should prescribe in line with product licensing as summarised in the table below:-

	Weight range	Dose
Jext	15-30kg	150 micrograms
	>30kg	300 micrograms
EpiPen	Between 7.5 to 25kg	150 micrograms (EpiPen Junior)
	>25kg	300 micrograms

4. For educational material produced by manufacturer see links:-, [EpiPen](#), [Jext](#)  
Other resources see links:, [EpiPen](#), [Jext](#) (key differences between devices)

### 3.7 Mucolytics

**Carbocysteine** 375mg caps, 250mg/5ml oral solution

**GREEN**

**Acetylcysteine** 600mg Sugar-free **effervescent tablets**

**GREEN**

1. [NICE NG115](#) COPD in over 16s: diagnosis and management:
  - Consider mucolytic drug therapy for people with a chronic cough productive of sputum.
  - Only continue mucolytic therapy if there is symptomatic improvement (for example, reduction in frequency of cough and sputum production).
  - Do not routinely use mucolytic drugs to prevent exacerbations in people with stable COPD.