Inhaled Budesonide (Pulmicort Turbuhaler®) Nova Scotia Health Prescribing Protocol

Client Information		
Name: _____ Preferred Name/Alias: _____ HCN: _____ Street Address: _____ City/Town: _____ Province: _____ Postal Code: _____ Phone Number: _____ Date of Birth: _____ Age: _____ Gender: □Male □Female □Gender X □Undifferentiated		
Eligibility Confirmation	Age ≥ 18 years	□Yes □No
	Positive COVID-19 test (PCR or rapid antigen)?	□Yes □No
	Symptom onset within previous 14 days?	□Yes □No
	Non-severe COVID-19 symptoms (i.e. no acute difficulty breathing, not requiring new or additional supplemental oxygen, intravenous fluids, or physiological support)	□Yes □No
	New, worsening or ongoing respiratory symptoms (cough, shortness of breath) Record presence of additional symptoms: fever (chills, sweats), headache, runny nose/nasal congestion, loss of smell/taste, sore throat, other _____	□Yes □No
	All questions above require a yes response to be eligible	
Medical History	Allergies, medical conditions, and medications are updated on patient record	□Yes
	Does the patient have a known allergy to budesonide?	□Yes - STOP □No
	Is patient already taking inhaled budesonide or another inhaled corticosteroid (ICS)? a) If already taking inhaled budesonide at a dose lower than 800 mcg bid, may increase dose b) If taking another ICS at a dose equivalent to ≤ 800 mcg bid of budesonide, may substitute existing ICS to budesonide c) If taking an ICS as part of a combination therapy puffer, do not proceed	□Yes □No
	Is patient unable to use the dry powdered inhaler device, or perform forceful inhalation required to receive the budesonide dose?	□Yes - STOP □No

Assessment	**Select one of the following:** □ The patient is eligible for inhaled budesonide All eligibility criteria above are met and medical history screen to does not indicate contraindications to inhaled budesonide (Pulmicort Turbuhaler®) □ Patient is not eligible for inhaled budesonide (Pulmicort Turbuhaler®) due to: □ Patient referred to Physician or Nurse Practitioner for assessment due to:
Prescription	**Select one of the following:** *Preferred option when 400 mcg/inhalation inhaler is available:* □ Budesonide Dry Powdered Inhaler (Pulmicort Turbuhaler 400 mcg®) 800 mcg (2 puffs) inhaled bid x 14 days or until symptom recovery Dispensed as: Pulmicort 400 mcg/inhalation Turbuhaler x 1 inhaler (200 doses) *Alternative options when 400 mcg/inhalation inhaler is NOT available:* □ Budesonide Dry Powdered Inhaler (Pulmicort Turbuhaler 200 mcg®) 800 mcg (4 puffs) inhaled bid x 14 days or until symptom recovery Dispensed as: Pulmicort 200 mcg/inhalation Turbuhaler x 1 inhaler (200 doses) □ Budesonide Dry Powdered Inhaler (Pulmicort Turbuhaler 100 mcg®) 800 mcg (8 puffs) inhaled bid x 14 days or until symptom recovery Dispensed as: Pulmicort 100 mcg/inhlation Turbuhaler x 1 inhaler (200 doses) Rinse mouth after use to reduce risk of adverse events (oral thrush, hoarseness, throat irritation) and systemic absorption. ***Note: Do NOT substitute for nebules, alternative inhaled corticosteroids, or oral/IV corticosteroids.***

Patient Education and Follow-up	**Patient education provided on correct product usage and self monitoring for efficacy and toxicity as below.** **Efficacy monitoring** • If COVID-19 signs or symptoms improving, or symptoms are stable, ensure continuation of therapy • If COVID-19 signs or symptoms not improving and require support from another healthcare provider for management refer to MD/NP/811 •If COVID-19 progression to severe disease refer to ED or call 911 immediately if severe symptoms such as: difficulty breathing, severe chest pain, loss of consciousness, or feelings of confusion. **Toxicity monitoring** • Oral thrush • Hoarseness • Throat Irritation □ Faxed notification to primary care provider regarding: _____ Pharmacist follow-up plan : _____ Date (if applicable):
Pharmacist Certification	I have assessed the patient • Patient consent was obtained • The written prescription/assessment is within my scope of practice, skills, competencies, experience and is within the prescribing standards as outlined by the council. • If an authorized prescription is being dispensed by the same prescribing pharmacist, the patient has been informed that in this case there is one less health care professional assessing the appropriateness of therapy for the above indication. Pharmacist Name: _____ Signature: _____ NSCP #: _____ Date: _____

Prescription Hard Copy

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I, the assessing pharmacist, have seen and assessed the patient: ☐ In-Person ☐ Virtually

- The written prescription/assessment if any is within my scope of practice, skills, competencies, experience and is within the prescribing standards.
- If an authorized prescription is being dispensed by the same prescribing pharmacist, the patient has been informed that in this case there is one less health care professional assessing the appropriateness of therapy for the above indication.

_____ _____

Pharmacist Signature/License # Date

Fax Cover Letter

To:	From:
Fax:	Pages:
Phone:	Date
Re: Pharmacist Assessment Budesonide for sx of C-19	cc:

Comments

Physician/NP Prescribing Notification

☐ Response Required ☐ For Your Records

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HCN: _____
Street Address: _____ City/Town: _____
Province: _____ Postal Code: _____
Phone Number: _____
Date of Birth: _____ Age: _____

Your patient has been assessed by the pharmacist and deemed appropriate for treatment with inhaled budesonide for COVID-19 respiratory symptoms under the Inhaled Budesonide (Pulmicort Turbuhaler®) Prescribing Protocol. The patient was prescribed the following therapy:

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I, the assessing pharmacist, have seen and assessed the patient: ☐ In-Person ☐ Virtually

- Pharmacist Follow-up Plan:
- The written prescription/assessment if any is within my scope of practice, skills, competencies, experience and is within the prescribing standards.
- If an authorized prescription is being dispensed by the same prescribing pharmacist, the patient has been informed that in this case there is one less health care professional assessing the appropriateness of therapy for the above indication.

_____ _____

Pharmacist Signature/License # Date