

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: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender X <input type="checkbox"/> Undifferentiated		
Eligibility Confirmation	Age ≥ 18 years	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Positive COVID-19 test (PCR or rapid antigen)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Symptom onset within previous 14 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Non-severe COVID-19 symptoms (i.e. no acute difficulty breathing, not requiring new or additional supplemental oxygen, intravenous fluids, or physiological support)	<input type="checkbox"/> Yes <input type="checkbox"/> 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 _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>All questions above require a yes response to be eligible</i>		
Medical History	Allergies, medical conditions, and medications are updated on patient record	<input type="checkbox"/> Yes
	Does the patient have a known allergy to budesonide?	<input type="checkbox"/> Yes - STOP <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Is patient unable to use the dry powdered inhaler device, or perform forceful inhalation required to receive the budesonide dose?	<input type="checkbox"/> Yes - STOP <input type="checkbox"/> No

<p>Assessment</p>	<p>Select one of the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> 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®) <input type="checkbox"/> Patient is not eligible for inhaled budesonide (Pulmicort Turbuhaler®) due to: <input type="checkbox"/> Patient referred to Physician or Nurse Practitioner for assessment due to:
<p>Prescription</p>	<p>Select one of the following:</p> <p><u>Preferred option when 400 mcg/inhalation inhaler is available:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Budesonide Dry Powdered Inhaler (Pulmicort Turbuhaler 400 mcg®) 800 mcg (2 puffs) inhaled bid x 14 days or until symptom recovery <p>Dispensed as: Pulmicort 400 mcg/inhalation Turbuhaler x 1 inhaler (200 doses)</p> <p><u>Alternative options when 400 mcg/inhalation inhaler is NOT available:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Budesonide Dry Powdered Inhaler (Pulmicort Turbuhaler 200 mcg®) 800 mcg (4 puffs) inhaled bid x 14 days or until symptom recovery <p>Dispensed as: Pulmicort 200 mcg/inhalation Turbuhaler x 1 inhaler (200 doses)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Budesonide Dry Powdered Inhaler (Pulmicort Turbuhaler 100 mcg®) 800 mcg (8 puffs) inhaled bid x 14 days or until symptom recovery <p>Dispensed as: Pulmicort 100 mcg/inhalation Turbuhaler x 1 inhaler (200 doses)</p> <p>Rinse mouth after use to reduce risk of adverse events (oral thrush, hoarseness, throat irritation) and systemic absorption.</p> <p>Note: Do NOT substitute for nebulers, alternative inhaled corticosteroids, or oral/IV corticosteroids.</p>

<p>Patient Education and Follow-up</p>	<p>Patient education provided on correct product usage and self monitoring for efficacy and toxicity as below.</p> <p>Efficacy monitoring</p> <ul style="list-style-type: none"> • 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. <p>Toxicity monitoring</p> <ul style="list-style-type: none"> • Oral thrush • Hoarseness • Throat Irritation <p><input type="checkbox"/> Faxed notification to primary care provider regarding: _____</p> <p>Pharmacist follow-up plan : _____</p> <p>Date (if applicable): _____</p>
<p>Pharmacist Certification</p>	<p>I have assessed the patient</p> <ul style="list-style-type: none"> • 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. <p>Pharmacist Name: _____</p> <p>Signature: _____</p> <p>NSCP #: _____</p> <p>Date: _____</p>

Prescription Hard Copy

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Province: _____	Postal Code: _____
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Date of Birth: _____	Age: _____

<input type="checkbox"/>	<p><u><i>Preferred option when 400 mcg/inhalation inhaler is available:</i></u></p> <p>Budesonide Dry Powdered Inhaler (Pulmicort Turbuhaler 400 mcg[®]) 800 mcg (2 puffs) inhaled bid x 14 days or until symptom recovery</p> <p>Dispensed as: Pulmicort 400 mcg/inhalation Turbuhaler x 1 inhaler (200 doses)</p>
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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

Client Information	
Name: _____	Preferred Name/Alias: _____
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:

<input type="checkbox"/>	<p><u><i>Preferred option when 400 mcg/inhalation inhaler is available:</i></u></p> <p>Budesonide Dry Powdered Inhaler (Pulmicort Turbuhaler 400 mcg®) 800 mcg (2 puffs) inhaled bid x 14 days or until symptom recovery</p> <p>Dispensed as: Pulmicort 400 mcg/inhalation Turbuhaler x 1 inhaler (200 doses)</p>
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- 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