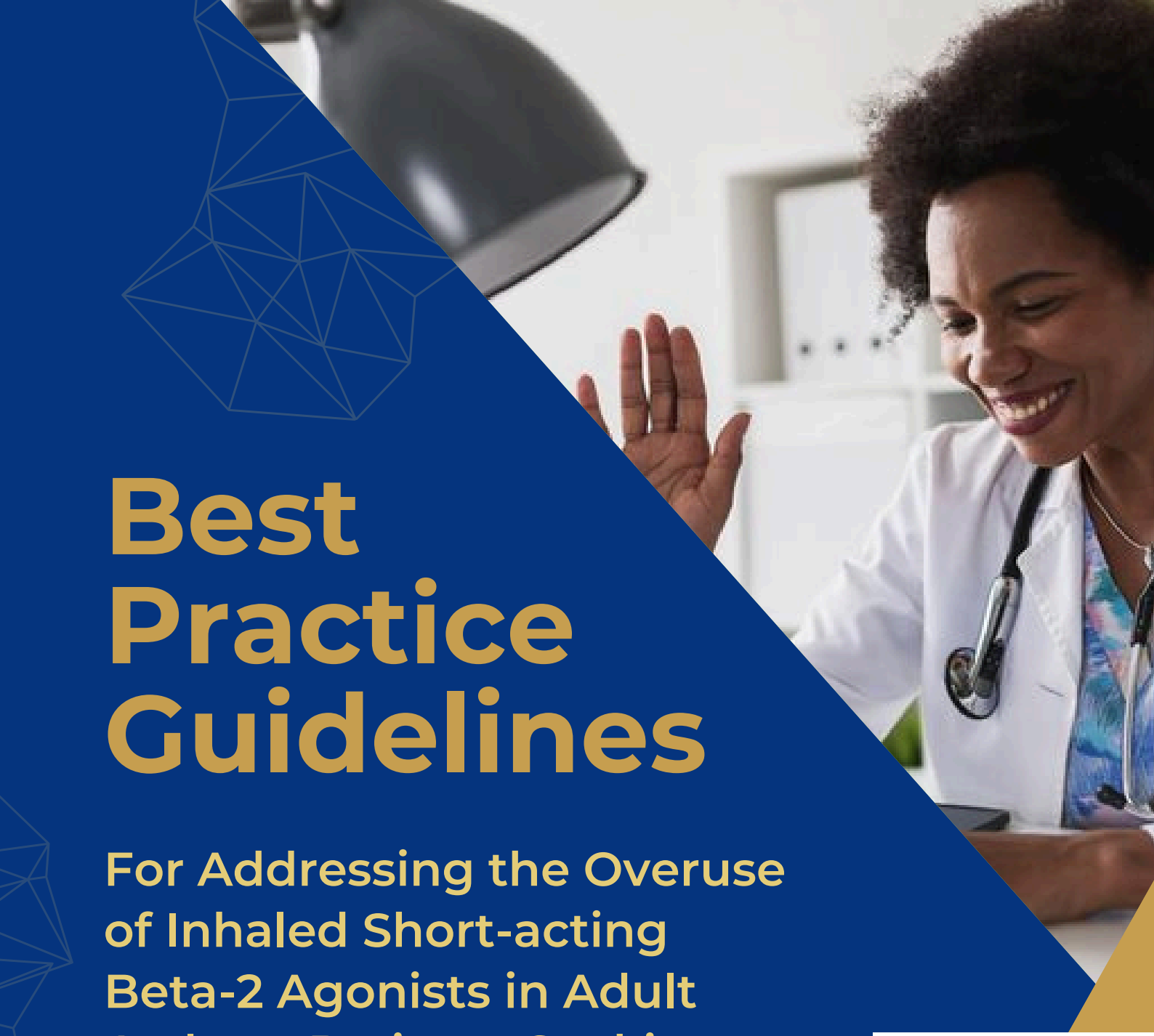

Best Practice Guidelines

For Addressing the Overuse of Inhaled Short-acting Beta-2 Agonists in Adult Asthma Patients Seeking Treatment via Online Prescribers

DiCE

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About this document

This Best Practice Guidance (BPG) is based on the collective experience of established online healthcare providers who participate in the Digital Clinical Excellence (DiCE) Forum, with expert input from Asthma + Lung UK and Taskforce for Lung Health. The BPG was developed through working group virtual meetings, the purpose of which was to gather and review existing evidence and contemporary practices, and to form a consensus on a best practice approach to enhance the quality and safety of online / remote prescribing within the independent pharmacy sector.

DiCE BPG aims to align with existing professional and regulatory standards, but also to broaden and strengthen them from an industry perspective. This is in recognition of the fact that rapidly progressing and expanding areas of care are often developing at a faster pace than professional or regulatory standards are published. BPGs are not intended to replace or contest any current professional or regulatory standards. Recommendations are regularly reviewed and updated where necessary.

DiCE BPG applies only to prescribers and is not intended for use by healthcare practitioners operating under a Patient Group Direction. In addition, while DiCE BPG may be useful for prescribers operating outside of the United Kingdom, it is not written with this purpose in mind and some recommendations may not apply.

This guidance has been developed for digital asynchronous prescribing of short-acting beta-2 agonists (SABAs) in asthma patients, with a focus on ways in which online prescribers can minimise the potential for overuse of these medications.

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DiCE Best Practice Guidelines are not intended to replace current prescribing information. Prescribers should always refer to the BNF and Summary of Product Characteristics, and any relevant national and NICE guidelines

About digital asynchronous prescribing

The term 'digital asynchronous prescribing' describes the process of online / remote prescribing of medicines using a form-based assessment, without a real-time conversation between prescriber and patient.

Digital asynchronous prescribing is subject to the same legal requirements and regulations as in-office primary care, including the Royal Pharmaceutical Society (RPS) competency framework for consultations and prescribing governance that applies to all prescribers in England and Wales [1].

In addition, online prescribers are required to follow guidance and professional standards set by the regulatory body relevant to their profession, for example the General Medical Council (GMC) and the General Pharmaceutical Council (GPhC) [2-4]. In England, registered online pharmacies and other prescribing platforms employing doctors as part of the prescribing team, thereby falling under the remit of the GPhC, may also be required to abide by the standards of the Care Quality Commission (CQC), who regularly inspect the quality of care provided to drive improvements in safety and prescribing policies [5].

When conducted in a well-regulated setting with good risk management systems, routine reviews to drive continuous learning improvement, and careful consideration of how information is provided to patients, asynchronous prescribing can be effective in replacing some in-office primary care visits, providing timely care and increased convenience for patients [6–11].

For more general information on professional standards and guidance relevant to digital asynchronous prescribing, refer to the following documents developed by UK regulatory and professional bodies:

- Guidance for registered pharmacies providing pharmacy services at a distance, including on the internet (GPhC, 2025) [12]
- Good practice in prescribing and managing medicines and devices (GMC, 2021) [4]
- Policy for providing medicines online (RPS, 2019) [13]
- Is a remote consultation appropriate? (GMC, 2019) [14]
- Remote prescribing high-level principles (Joint statement by UK-wide healthcare regulators, royal colleges and faculties, 2019) [15]
- The state of care in independent online primary health services (CQC, 2018) [5]

About Digital Clinical Excellence 'DiCE'

DiCE was established in March 2019 to provide a collective voice and support to the growing community of UK digital healthcare providers. The network aims to drive excellence in digital care standards to support clinical care improvement and safety in digital healthcare. DiCE members are senior clinical leaders from online clinical service providers who ensure collective governance for DiCE. There is no commercial focus or activity within the network.

DiCE aims to work collaboratively within the industry and with relevant professional bodies and healthcare regulators to produce its Best Practice Guidance. However, these are industry produced and should not be regarded as being endorsed by any professional body or regulator, who have their own standards. Healthcare professionals are reminded that the only statutory standards that must be adhered to are those produced by the UK healthcare regulators. Established national guidance such as those produced by NICE, SIGN or other statutory bodies must also be followed.

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1. Inhaled medications for treating asthma

Despite major therapeutic advances over the past 30 years, asthma remains a serious global health problem [16,17].

In the UK alone, an estimated 7.2 million adults and children are living with asthma. This equates to around 1 in 9 adults and 1 in 8 children [18–21]. In the majority of cases, a patient's asthma can be well controlled and have a minimal impact on their daily life. However, asthma exacerbations (also known as asthma attacks or flare-ups) can lead to hospitalisation and can be fatal. A recent analysis by Asthma + Lung UK showed that more than 12,000 people in the UK have died from asthma in the past 10 years, equating to around 4 patients per day [22]. Many more patients continue to be at risk, with around 55,000 emergency hospital admissions for asthma recorded in 2021/2022 [22].

The 2014 National Review of Asthma Deaths (NRAD) report found that two-thirds of asthma deaths are preventable and identified three key risk factors [23]:

- Overuse of 'reliever inhalers' (as-needed therapy), specifically those containing a short-acting beta-2 agonist (SABA) – SABA overuse is an indicator of poorly controlled asthma
- Underuse of 'preventer inhalers' (maintenance therapy) containing inhaled corticosteroids (IHS) – sometimes known as 'controller inhalers'
- Lack of follow-up after an A&E visit for asthma.

Worryingly, behavioural insights gathered in a 2024 survey by Asthma + Lung UK indicate that nearly 1 in 3 patients (31%) rely on their reliever inhaler to manage their asthma, indicating poorly controlled asthma and an increased risk of asthma-related death [22]. The survey also found that 69% (6076 out of 8766) of participants were not receiving the three elements of [DW1] [MOU2] basic asthma care [22]. According to good practice recommendations from the National Institute for Health and Care Excellence (NICE), patients should be offered an annual asthma review, an inhaler technique check, and a written asthma action plan [24].

Treatment goals for asthma have now started to shift from short-term symptom control to long-term symptom prevention reflecting scientific evidence cited in national and international guidelines [25–27]. Importantly, a new asthma guideline and treatment pathway developed by NICE – together with the Scottish Intercollegiate Guideline Network (SIGN) and British Thoracic Society (BTS) – has called for an end to prescribing SABA monotherapy in asthma patients aged 12 years and over (see section 1.2 below) [27].

1.1 Short-acting beta-2 agonists and the consequences of overuse

SABAs are the active ingredient of some of the most commonly prescribed lifesaving reliever inhalers. They usually work within 5 minutes, and their effects can last for up to 4 hours. Examples of SABA reliever inhalers include salbutamol and terbutaline [28,29].

Inhalers containing a long-acting beta-2 agonist (LABA) as the active ingredient have a bronchodilator effect that last for 12 hours or more [30]. Most LABAs do not work fast enough for use as reliever inhalers and are not recommended as monotherapy for this purpose [27]. Formoterol is currently the only licensed beta-2 agonist that is both long-acting and fast-acting, albeit not licenced as only a reliever treatment. Sometimes referred to as a FABA, formoterol has a similar time to onset of relief as SABAs [31].

Acting directly on beta-2 adrenergic receptors, both SABA and LABA relievers relax the smooth muscle in the airways, enlarging them to allow air to move more freely [29,30]. However, reliever inhalers are intended for use on an occasional basis only. They do not address the underlying inflammation in the airways and have no known ability to modify the disease course or pathophysiology of asthma [16].

The recommendations in this document are intended to provide best-practice guidance for preventing SABA overuse in the asynchronous online setting. SABA overuse is often defined as using three or more prescribed reliever inhalers per year, which equates to around 1.5 puffs or more per day [32]. However, some definitions (for example, the one currently used by NHS England) define overuse as using three or more inhalers within 6 months [33].

As outlined by the 2014 NRAD report, SABA overuse is associated with poor symptom control, which increases the risk of asthma exacerbations, hospitalisation and death [23]. The same report identified that 56% of cases studied had been prescribed six or more reliever inhalers within a year, 39% had been prescribed 12 or more, and 4% had received an alarming 50 or more [23].

High SABA use is associated with an increased risk of adverse asthma outcomes. The SABINA I observational study program looking at SABA use across multiple European countries, highlighted correlation between SABA overuse (three or more inhalers per year) and continued exacerbation, showing that patients remained at risk as their treatment was suboptimal [34].

A UK substudy of SABINA in 574,913 asthma patients affirmed the widespread overuse of SABA in the UK, finding that 38% of patients were prescribed three or more SABA inhalers per year. Using three or more SABA inhalers per year increased the risk of asthma exacerbation by 20% in patients with mild asthma and by 24% in patients with moderate-to-severe asthma [35].

These exacerbations are often managed using oral corticosteroids (OCS), putting the patient at further risk of side effects which may arise from cumulative use of OCS [36].

1.2 Addressing the overuse of short-acting beta-2 agonists in patients with asthma

Once a mainstay of asthma management, since 2019, SABA monotherapy is no longer recommended by the Global Initiative for Asthma for patients over 6 years of age or by BTS [16]. The unified BTS/NICE/SIGN guideline, published in November 2024, recommends that all patients with uncontrolled asthma over 12 years of age (and currently on the treatment pathway recommended by previous NICE and BTS/SIGN guidelines) should be switched from SABA monotherapy to as-needed use of an anti-inflammatory reliever (AIR) [27].

AIR therapy is the combination of low-dose inhaled corticosteroid (ICS) together with a FABA (e.g. formoterol), administered as needed in a single inhaler [16,27]. The ICS acts on the underlying airway inflammation, while the FABA provides rapid relief from bronchospasm. When used as preventer therapy, this combination is often referred to as Maintenance and Reliever Therapy, or MART [16,27,37].

The unified BTS/NICE/SIGN guideline recommends switching preventer therapy to low-dose MART for people with asthma that is not controlled on:

- Regular low-dose ICS plus SABA as needed
- Regular low-dose ICS/LABA combination inhaler plus SABA as needed
- Regular low-dose ICS and supplementary therapy (leukotriene receptor antagonist [LTRA]) plus SABA as needed.
- Regular low-dose ICS/LABA combination inhaler and supplementary therapy (LTRA) plus SABA as needed [27].

Switching preventer therapy to moderate-dose MART is recommended for people with asthma that is not controlled on:

- Regular moderate-dose ICS plus SABA as needed
- Regular moderate-dose ICS/LABA combination inhaler plus SABA as needed
- Regular moderate-dose ICS and supplementary therapy (LTRA or LAMA, or both) plus SABA as needed
- Regular moderate-dose ICS/LABA combination inhaler and supplementary therapy (LTRA or long-acting muscarinic antagonist [LAMA], or both) plus SABA as needed [27].

The unified BTS/NICE/SIGN guideline also makes recommendations for paediatric patients (aged <12 years), but these are outside the scope of this DiCE BPG [27]. See the full guideline for full details.

One of the challenges facing clinicians is that patients are often reluctant to stop relying on their SABA reliever inhalers, overvaluing the immediate relief that SABAs provide and undervaluing the need to use preventer therapy even when they feel well [38,39]. Asynchronous prescribing providers may wish to incorporate validated questionnaires into their form-based assessments to evaluate a patient's SABA reliance. For example, a SABA Reliance Questionnaire (also known as a Reliever Reliance Test) [40,41] or the six-question variant of the Asthma Control Questionnaire (ACQ) [42].

To optimise patient outcomes, the Taskforce for Lung Health has called for uniform implementation of asthma review services across the UK. As part of best practice, patients should receive a full review of asthma medicines, inhaler technique check and a written asthma plan at least once a year and after every exacerbation requiring hospital admission or support with oral steroids[24]. It is well known that many people with asthma do not use their preventer (ICS) inhaler effectively, often because they have not been properly taught how and do not receive an annual inhaler check [43,44].

2. Why is a best practice approach needed?

2.1 Providing a safe and trustworthy service

Appropriate SABA use relies on prescribers ensuring that each patient has an individualised inhaler regimen, in line with unified BTS/NICE/SIGN guidance [27], and that they are able to use their inhaler(s) effectively. Establishing a best practice approach for asynchronous prescribing of SABAs is essential to minimise their overuse. It is also essential to reassure patients that their medication is coming from trustworthy pharmacies and clinicians who are aware of any risks and clear on their responsibility to protect patients.

Online prescribers have a duty to provide a safe service for all patients seeking treatment with a SABA inhaler, and to follow the professional standards set by the regulatory body relevant to their profession [2–4]. For example, the GMC professional standards state that medicines should only be dispensed if the prescriber feels that they have adequate knowledge of the patient's health, and are satisfied that the medicines serve the patient's needs [4]. Therefore, the online prescriber of a SABA inhaler will need to satisfy themselves, and the patient, that they have adequate information relating to the patient's current condition and management to be able to make a justifiable decision to treat. This should include inhaler technique and information about managing exacerbations.

Newly updated guidance from the GPhC states that prescribers and providers are responsible for verifying that information provided to them is reliable so that the supply is both safe and clinically appropriate for the patient (e.g. assessing the number of supplies requested and considering whether the patient has obtained medication from a GP or another provider.) This verification should be through contacting the patient's GP, their regular prescriber, or a third-party provider, or checking the patient's clinical records, with their consent, before making a prescription. As asthma is a long-term condition, monitoring arrangements should be in place before making a prescription [12].

It is the consensus of the DiCE Working Group that there is no completely foolproof way to safeguard against wilful misuse of SABA in the context of digital asynchronous prescribing. However, comprehensively risk-assessed patient verification steps should be taken to identify patients suitable for treatment. It is expected that all prescribers using asynchronous form-based assessments have undertaken a comprehensive risk assessment of the service being provided, in line with current statutory guidance and standards [2,4,12].

This risk assessment should include, but is not limited to:

- The risks of providing medicines asynchronously based solely on a questionnaire model.
- How prescribers will verify the reliability of the information they receive.
- The risks of prescribing treatment without consent to communicate with other necessary healthcare providers involved in the patient's care such as their GP.
- Safeguarding vulnerable people.
- Sharing and transferring information to the patient's regular prescriber or healthcare provider.
- How prescribers will adequately counsel, provide advice and safety net patients.

If the prescriber feels that a patient's asynchronous form-based assessment does not provide sufficient information to make a safe prescribing decision, and further information is required from the patient, it may be that a telephone or video consultation (or other two-way communication method) is needed.

Best practice in digital asynchronous prescribing requires that appropriate screening, prescribing and monitoring is undertaken by professionals meeting the requirements of the RPS competency framework [1]. To ensure high-quality provision of care, online prescribers should proactively audit and review the quality and safety of their service. This includes analysing prescribing trends to be able to identify any inappropriate prescribing and supply of SABA inhalers.

In addition, consideration should be given to providing pharmacy teams with training on SABA inhalers for asthma, as well as pharmacists having access to a prescriber of appropriate seniority who can provide further advice and support.

Focus areas for training may include:

- Making clear the dangers of SABA over-prescribing and the benefits of stepping up therapy to ICS when indicated and when to seek help and further advice about maintenance treatment.
- How to educate patients on the importance of using their preventer (ICS) inhaler even when they are not experiencing asthma symptoms, and that a chronic disease like asthma requires long-term treatment.
- How to educate patients in the correct use of inhalers in the asynchronous setting – improved inhaler technique is especially important for addressing overuse of SABA
- How to check inhaler technique via a video call, if required.
- Signposting to supportive educational materials e.g. from Asthma and Lung UK.

When designing their assessment-based tools, online providers may wish to refer to asthma review pathways developed by and used within individual NHS Trusts [45–47].

2.2 Information sharing and patient consent

Current professional and regulatory standards recommend that online prescribers request patient consent to share their treatment details with their other healthcare professionals involved in their care (for example, their GP) when prescribing prescription-only medicines [2,4].

Patients requesting SABA treatment should be asked to consent to GP notification. If consent is not provided and a prescription is made, prescribers must record their justification for making the prescription based on the information available. They should also inform the patient about the importance of sharing information between healthcare providers to ensure continuity of care, and the potential risks of not sharing this information.

Prescribers should keep a clear written record of treatment decisions made based on the information provided by the patient, particularly if a SABA is prescribed without obtaining consent for GP notification. This is in line with current professional and regulatory standards [2,4].

In cases where failing to share information could pose a risk to patient safety, the prescriber should inform the patient that they cannot prescribe and signpost the patient to appropriate alternative services.

2.3 Environmental considerations

Encouraging the appropriate prescribing of SABA inhalers, combined with better patient education and management, will help minimise to SABA overuse, leading to improved health outcomes and a reduced environmental impact, presenting a valuable opportunity to support NHS 'Net Zero' goals [48]. It is also important to note that not all SABA inhalers have the same carbon footprint; dry powder inhalers have a lower environmental impact than, for example, salbutamol metered-dose inhalers. In the UK, uncontrolled asthma is associated with much higher greenhouse gas emissions than controlled asthma, and >60% of those emissions are attributable to SABA inhaler use [49]. The increased risk for asthma exacerbations associated with SABA overuse further adds to the carbon footprint of these medicines. In the UK, asthma exacerbations account for >720,000 tons of carbon dioxide annually [50].

Online providers should take steps to encourage the safe disposal and recycling of emptied or expired inhalers. Patients should be educated to dispose of emptied or expired inhalers safely, e.g. by returning the devices to a pharmacy for recycling or incineration rather than putting them in their household recycling or in general waste [51]. Pilot studies have also successfully trialled the use of postal inhaler returns alongside in-person drop-off, to improve patient access to green recycling schemes [52]. These green initiatives are in line with the RPS prescribing competency framework [1], which states that prescribers should "consider the impact of prescribing on sustainability, as well as methods of reducing the carbon footprint and environmental impact of any medicine."

In a recently published paper, members of the Taskforce for Lung Health called on the NHS to establish a funded National Inhaler Recycling Scheme that provides green recycling solutions for all kinds of inhalers, including gas capture for inhalers containing propellants [52].

3. Considering the patient journey

It is the consensus of the DiCE Working Group that, in most cases, patients wishing to access SABA treatment online are likely to already have an active or expired SABA prescription from their GP.

Patients may be looking to switch back to their previous SABA inhaler following recent changes in their local formulary according to the NHS drive to promote greener alternatives to some commonly prescribed SABA inhalers.Also patients who have been changed to combination inhalers may try to obtain a previously prescribed SABA.

The Taskforce for Lung Health has heard from multiple patients who have had concerns with their inhaler switching care. The Taskforce estimates that around 1 in 3 patients didn't feel well-informed about their switch and that around 40% didn't have a follow-up appointment post-switch. Efforts should be made to further educate these patients on the environmental benefits of the greener alternative(s) they have been switched to.

Other reasons for seeking an online prescription may include wanting to:

- More easily access SABA treatment than via their GP (e.g. people with mobility issues or people with limited knowledge of English who prefer to use a translated website)
- Supplement their NHS prescription (e.g. an extra inhaler for the car, replace a lost inhaler)
- Obtain multiple inhalers at once, in a number not permitted by their GP (see section 4.2)
- Access SABA treatment for a child in their care (see section 4.2)

4. Recommendations from the DiCE Working Group

4.1 Who should follow these recommendations?

The following recommendations are intended as best practice guidance for developing form-based assessments to allow online providers to minimise the potential overuse of SABAs in patients with asthma.

It is the consensus of the DiCE Working Group that a maximum of two SABA inhalers should be prescribed following a form-based assessment. If patient does not consent to sharing information with their GP, prescribers should consider declining the prescription. If they do decide to prescribe a SABA based on the information provided, no more than one inhaler may be prescribed and the reason for prescribing should be documented. If there are safety concerns, this should be discussed with the patient and every attempt made to allow transfer of information back to the registered GP.

The 6-item Asthma Control Questionnaire (ACQ-6) and five-item Asthma Control Test (ACT) are commonly used patient-reported outcomes for measuring how well a patient's asthma is being controlled [42,53]. It is recommended that the ACQ-6 or ACT be administered as part of any form-based assessment for access to SABA therapy.

The ACQ-6 has a minimum value of 0 (representing very well controlled asthma) and maximum value of 6 (representing extremely poorly controlled asthma); well-controlled asthma is indicated by an ACQ-6 score ≤0.75 [42]. The ACT has a minimum value of 5 (representing extremely poorly controlled asthma) and maximum value of 25, with a score of 20–25 indicating well-controlled asthma [52].

An alternative option is to use the Royal College of Physicians 3 Questions (RCP-3Qs) for Asthma, which can be used by patients to self-report their asthma control over the past week or month [54].

It is recommended that online providers consider the visibility and clarity of their messaging around the potential risks of SABA overuse. It is also recommended that web pages should include or direct the patient to clear information on the environmental impact of different inhaler types (e.g. the NICE/SIGN/BTS patient decision aid [55]). Further information can be found on supportive regulated websites and helplines such as Asthma and Lung UK.

These recommendations are intended to complement current prescribing information for SABA use in patients with asthma. Online providers should always refer to the BNF and Summary of Product Characteristics before prescribing a SABA in patients seeking treatment. Relevant national guidelines should also be followed.

4.2 Recommendations for initial consultation and prescribing

A patient with asthma may be eligible to access SABA treatment in the asynchronous setting:

– If the patient is over the age of 18 and has previously been prescribed a SABA reliever inhaler for asthma diagnosed by their GP or private doctor

- Patients with no formal diagnosis of asthma, or who have not previously been prescribed a SABA reliever inhaler for diagnosed asthma should be redirected to their GP or private doctor for further consultationor advised to use NHS 111.

– If the patient reports that that they have been prescribed fewer than 3 SABA reliever inhalers over the past 12 months, and available records support this

- Use of 3–5 SABA reliever inhalers within 12 months needs to be queried. Not all reasons for seeking additional inhalers are indicative of overuse (e.g. replacing a lost inhaler, wanting an extra inhaler for the car).
- No patient should need or be prescribed 6 or more SABA reliever inhalers within 12 months or more than 1 SABA in any one month. If a patient is requesting this amount of SABA treatment they should be referred for urgent review to their GP or call NHS 111.

– If the patient meets all medical criteria for prescribing a SABA, as outlined in the product information for the individual SABA medication being considered

- Access to any SABA therapy must be in accordance with the individual product licence.

Use caution when prescribing a SABA for asthma in the asynchronous setting:

– If the patient's shows that they have been prescribed 3–5 SABA reliever inhalers over the past 12 months

- The patient should be reminded that reliever inhalers are not intended for frequent use (3 or more puffs per week), as this could indicate poorly controlled asthma and an increased risk of asthma exacerbations.
- In order to make a safe prescribing decision, prescribers should establish the patient's reasons for seeking additional SABA inhaler(s) and their current asthma control and management.
- Prescribers may also wish to use this opportunity to capture information about the patient's current use of preventer inhalers or MART.

– If the patient is being treated with a leukotriene receptor antagonist (LTRA), even if their asthma is currently well controlled

- Treatment with an add-on oral LTRA may indicate a patient with more severe asthma than patients whose asthma is controlled by inhaled medicines only [16].

Consider not prescribing a SABA for asthma in the asynchronous setting:

– If the prescriber is unable to verify the patient's SABA reliever inhaler use history (or whether on combination treatment[12]

– If the patient's most recent ACQ-6 or ACT score indicated asthma that was not well-controlled [42,51], or the patient replies 'Yes' to more than one question of the RCP-3Qs for Asthma [54]

- A SABA reliever inhaler may still be suitable. However, in order to make a safe prescribing decision, prescribers should establish the patient's reasons for seeking treatment.
- Prescribers may also wish to use this opportunity to capture information about the patient's current use of preventer inhalers or MART.

Do not prescribe a SABA for asthma:

- If the patient is already on combination treatment (and AIR or MART regime)

– If the patient is under 18 years of age

- Patients under 18 who are seeking a SABA prescription should be redirected to their GP or private doctor.

– If the patient has not previously been prescribed a SABA reliever inhaler for asthma

- A SABA reliever inhaler may still be suitable for the patient but should be prescribed in the first instance by the patient's GP or private doctor.

– If the patient's record shows that they have been prescribed 6 or more inhalers over the past 12 months

- Recommend that the patient discusses other options for asthma control with their GP or private doctor
- Direct to them to online educational materials about the dangers of SABA overuse

– If the patient's most recent ACQ-6 or ACT score indicated asthma that was very poorly controlled [42,51], or the patient replies 'Yes' to all three of the RCP-3Qs for Asthma [54]

- Recommend that the patient discusses other options for asthma control with their GP or private doctor.

– If the patient is currently being managed with high-dose asthma therapies or continuous or frequent use of oral corticosteroids

- Recommend that the patient discusses other options for asthma control with their GP or private doctor.

– If the patient has been admitted to hospital for asthma-related reasons within the past 12 months

- Recommend that the patient discusses other options for asthma control with their GP or private doctor.

– If the patient has ever been in intensive care for asthma-related reasons

- Recommend that the patient discusses other options for asthma control with their GP or private doctor.

– If the prescriber suspects or it is confirmed that the patient is attempting to obtain SABA treatment for another person (e.g. for a child in their care)

- Inform the patient that they cannot obtain SABA medication on behalf of another person.
- For example, if the other person is a child in their care, they should consult their GP or private doctor for further advice.

– If the patient fulfils any of the contraindications for use of a SABA reliever inhaler, as outlined in the product information for the individual SABA medication being considered

- Access to any SABA therapy must be in accordance with the individual product licence.

4.3. Recommendations for monitoring and review

The consensus among DiCE Working Group members is that monitoring and review should take place at the time of prescription refill (repeat supply).

In order to conduct a risk assessment and make a safe prescribing decision, online prescribers should be able to access the patient's prescribing history and any accompanying notes from the previous prescriber(s).

As with any prescribed medicine, providers should ensure that patients are able to contact them to report any treatment-emergent side effects while using a SABA reliever inhaler.

Recommendations

In addition to the product's patient information leaflet, online prescribers should provide patients with:

- Advice around the advantages of using a personalised asthma action plan [56]
- Advice around correct inhaler technique.
- Advice around the importance of not overusing their SABA inhalers.
- Advice on how to self-report side effects of treatment to the MHRA using the Yellow Card online reporting tool for patients, with an emphasis on the importance of side effect reporting for black-triangle products.

Monitor and review patients at time of prescription refill

- Review should establish:
  - If the patient has been following their personalised asthma action plan.
  - Whether the patient feels that their asthma has been under control since the initial assessment – if they have experienced any asthma exacerbations, it is important to know how they were managed.
  - How often the patient has been using their inhaler(s) since the initial assessment.
  - If the patient has any concerns about using their inhaler – a video consultation may be indicated to help the patient understand how to use their inhaler correctly.

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