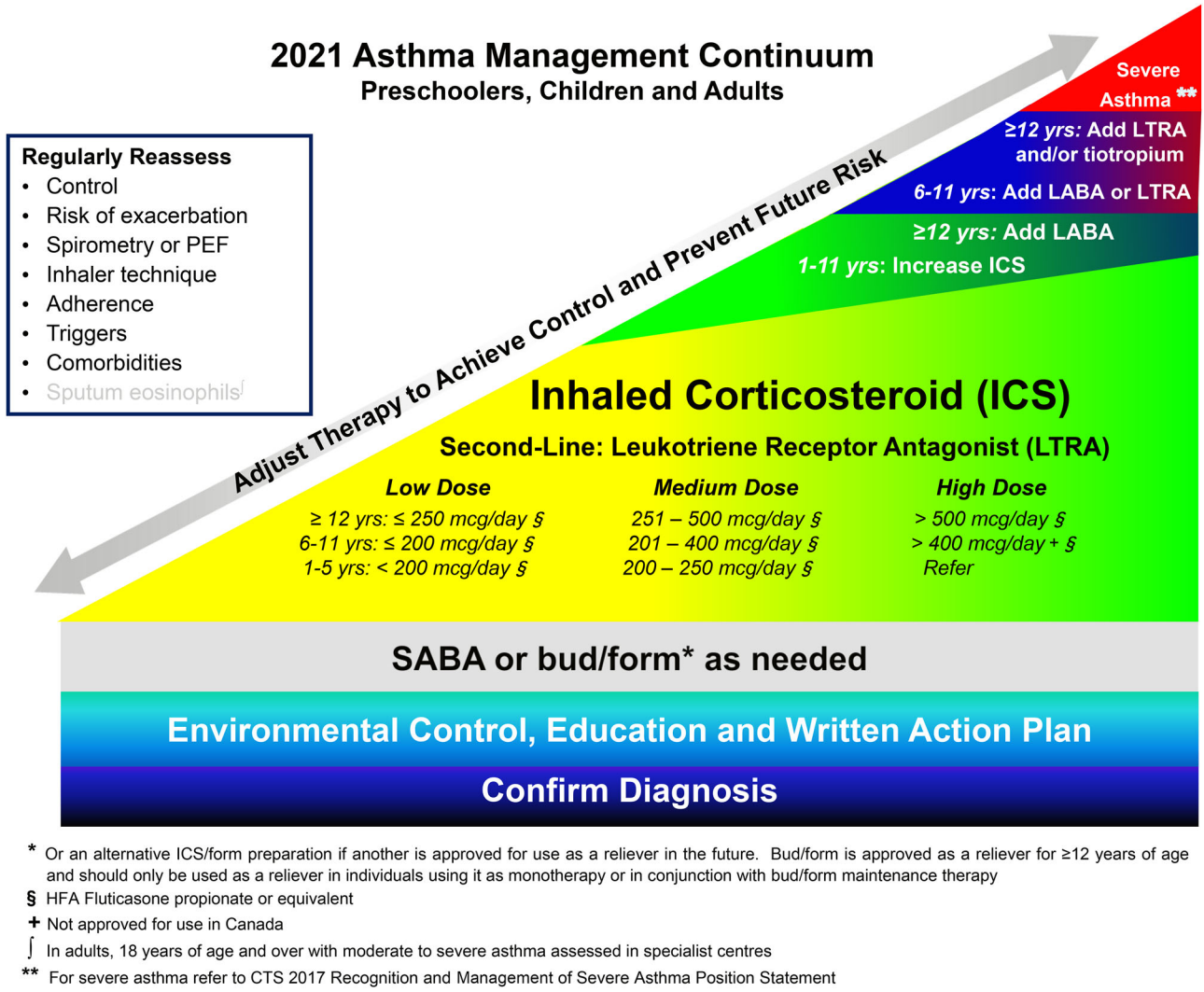


* Or an alternative ICS/form preparation if another is approved for use as a reliever in the future. Bud/form is approved as a reliever for ≥12 years of age and should only be used as a reliever in individuals using it as monotherapy or in conjunction with bud/form maintenance therapy

§ HFA Fluticasone propionate or equivalent

+ Not approved for use in Canada

∫ In adults, 18 years of age and over with moderate to severe asthma assessed in specialist centres

** For severe asthma refer to CTS 2017 Recognition and Management of Severe Asthma Position Statement

**Figure 1. 2021 Asthma management continuum preschoolers, children and adults.**

Management relies on an accurate diagnosis of asthma and regular reassessment of control and risk of exacerbation. All individuals with asthma should be provided with self-management education, including a written action plan. Adherence to treatment, inhaler technique, exposure to environmental triggers, and the presence of comorbidities should be reassessed at each visit and optimized.

Individuals with well controlled asthma on no medication or PRN SABA at lower risk of exacerbation can use PRN SABA, daily ICS + PRN SABA, and if ≥ 12 years of age PRN bud/form*.

Individuals at higher risk of exacerbation even if well-controlled on PRN SABA or no medication, and those with poorly-controlled asthma on PRN SABA or no medication should be started on daily ICS + PRN SABA. In individuals ≥ 12 years old with poor adherence despite substantial asthma education and support, PRN bud/form* can be considered. LTRA are second-line monotherapy for asthma. If asthma is not adequately controlled by daily low doses of ICS with good technique and adherence, additional therapy should be considered. In children 1-11 years old, ICS should be increased to medium dose and if still not controlled in children 6-11 years old, the addition of a LABA or LTRA should be considered. In individuals 12 years of age and over, a LABA in the same inhaler as an ICS is first line adjunct therapy. If still not controlled, the addition of a LTRA or tiotropium should be considered.

In children who are not well-controlled on medium dose ICS, a referral to an asthma specialist is recommended. After achieving asthma control, including no severe exacerbations, for at least 3-6 months, medication should be reduced to the minimum necessary dose to maintain asthma control and prevent future exacerbations.

HFA: hydrofluoroalkane; SABA: short-acting beta-agonist, LABA: long-acting beta-agonist, ICS: inhaled corticosteroid, LTRA: leukotriene receptor antagonist, bud/form: budesonide-formoterol in a single inhaler.

research methodology (including 1 epidemiologist); 1 primary care physicians appointed by the College of Family Physicians of Canada; 1 pharmacist who is a certified respiratory educator (CRE); and 1 nurse practitioner who is also a CRE. All author conflicts of interests are available at https://cts-sct.ca/guideline-library/. Patient and caregiver input was not sought in the development of this current guideline; this will be addressed in the next update.

This guideline was developed in accordance with the CTS guideline development process (https://cts-sct.ca/guideline-library/methodology/). The panel used the AGREE II checklist to guide the development of the guideline.[19]

### *Formulation of key clinical questions*

The PICO method was used, taking into consideration the **P**atient group or groups that should be addressed, the **I**ntervention or interventions that should be examined, the **C**omparison groups that should be part of the studies of the various interventions and the **O**utcome or outcomes of interest. The panel initially selected 2 PICO questions to find the best management strategy for 2 patient groups: 1) Individuals with well-controlled asthma on PRN SABA (very mild asthma) and 2) Individuals with poorly-controlled asthma on PRN SABA or well-controlled asthma on daily low