Banner Plans & Networks

Asthma Toolkit

Contents

These guidelines serve to assist in the management, documentation, and coding of clinical diagnoses. The intent of this document is to supplement, but not replace, the provider's clinical judgement.

Asthma Best Practices

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Asthma - Provider One Pager

POP
Provider One Pager

Asthma is a chronic respiratory disease characterized by airway inflammation and bronchoconstriction, leading to symptoms such as wheezing, shortness of breath, chest tightness, and coughing. Approximately 8.7% of the U.S. population is affected by asthma, with higher prevalence observed in females (64%) compared to males (36%). It is a leading chronic disease in children, affecting about 4.9 million individuals under the age of 18. Uncontrolled asthma contributes to increased healthcare utilization, including frequent emergency department visits and hospitalizations. Effective management and patient education are essential to improve outcomes and reduce the burden of asthma.[1,2]

Diagnosing Asthma

Signs & Symptoms
• Recurrent Wheezing: Wheezing when exhaling, which is a common sign of asthma in children • Shortness of Breath • Chronic Cough: Often worse at night or after exercise • Chest tightness or pain • Trouble sleeping caused by shortness of breath, coughing or wheezing • Coughing or wheezing attacks that are worsened by a respiratory virus, such as a cold or the flu

Risk Factors
• Family history of asthma or allergic conditions such as eczema or allergic rhinitis • Personal history of atopic diseases including hay fever and eczema • Exposure to air pollution, smoke, dust, strong fumes, or workplace irritants • Frequent respiratory infections in childhood • Living in an urban environment with high pollution levels • Obesity, which is linked to increased airway inflammation

Diagnosing Tools

Spirometry
• Standard Spirometry (FEV_1, FVC, FEV_1/FVC) • Bronchodilator Reversibility Test • Methacholine Challenge Test • Peak Expiratory Flow (PEF) Monitoring

Radiology
• Chest X-ray • High-resolution CT (HRCT) scan

Supporting Tools
• Fractional Exhaled Nitric Oxide (FeNO) Test • Allergy Testing • Blood Eosinophil Count

Assessing Asthma Severity

Assessing asthma severity is essential to guide treatment decisions. Severity is classified based on symptom frequency, nighttime awakenings, use of short-acting beta-agonists (SABA) for symptom control, interference with normal activity, and lung function measurements such as forced expiratory volume in one second (FEV_1) and the FEV_1/forced vital capacity (FVC) ratio.[3]

Severity Level	Symptoms
• Intermittent	Symptoms occur ≤2 days per week with rare exacerbations
• Mild Persistent	Symptoms occur more than 2 days per week, but not daily
• Moderate Persistent	Symptoms occur daily and may interfere with daily activities
• Severe Persistent	Symptoms occur throughout the day, causing significant limitations

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Treatment

Asthma management includes both pharmacologic and non-pharmacologic approaches to control symptoms, prevent exacerbations, and improve quality of life. The goal is to reduce airway inflammation and minimize the impact of triggers.[4]

Medications	Lifestyle & Non-Pharmacologic Treatment
• **Inhaled Corticosteroids (ICS):** First-line therapy for persistent asthma; they reduce airway inflammation and decrease the frequency of symptoms and exacerbations. • **Short-Acting Beta$_2$-Agonists (SABAs):** Provide rapid relief of acute asthma symptoms by relaxing bronchial smooth muscle. (e.g., albuterol, levalbuterol) • **Long-Acting Beta$_2$-Agonists (LABAs):** Used in combination with ICS for maintenance therapy in moderate to severe asthma; they help in sustained bronchodilation. (e.g., salmeterol, formoterol) • **Leukotriene Receptor Antagonists (LTRAs):** Oral medications that block leukotrienes, reducing inflammation and bronchoconstriction. (e.g., Montelukast) • **Biologic Therapies:** Target specific pathways in severe asthma, such as IgE or eosinophilic activity. Examples include omalizumab (anti-IgE) and mepolizumab (anti-IL-5).	• **Trigger Avoidance:** Identify and minimize exposure to allergens and irritants like pollen, dust mites, tobacco smoke, and air pollution. • **Asthma Action Plan:** Develop a personalized plan outlining daily management and how to handle worsening symptoms or attacks. • **Regular Monitoring:** Use peak flow meters to monitor lung function and detect early signs of exacerbations. • **Vaccinations:** Receive annual influenza and pneumococcal vaccines to prevent respiratory infections that can trigger asthma exacerbations. • **Smoking Cessation:** Quit smoking and avoid secondhand smoke to improve asthma control and overall lung health. • **Physical Activity:** Engage in regular exercise to enhance cardiovascular fitness and respiratory muscle strength, with appropriate management of exercise-induced symptoms.

When to Refer to a Specialist

Referral to an asthma specialist is appropriate when asthma remains uncontrolled despite standard therapy or when diagnostic uncertainty or advanced treatment options are needed.

Referral is recommended in the following situations:	
Frequent Exacerbations or Hospital Visits:	Two or more oral steroid bursts or hospitalizations in a year may indicate uncontrolled asthma
Poor Symptom Control:	If the patient remains symptomatic despite high-dose inhaled steroids and additional controllers
Diagnostic uncertainty:	Consider if symptoms may overlap with COPD, vocal cord dysfunction, or other respiratory conditions
Need for biologic therapy:	For patients with moderate-to-severe eosinophilic or allergic asthma who may qualify for injectables
Possible occupational or environmental triggers:	Specialized testing may be needed to confirm and manage exposure-related asthma
History of life-threatening asthma:	Includes prior intubation, ICU admission, or rapid symptom escalation
Allergy testing and immunotherapy consideration:	Especially for patients with persistent allergic asthma not responding to inhaled therapies

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Asthma – Action Plan

An asthma action plan helps patients manage their symptoms at home, know when to adjust medications, and understand when it's time to seek help. This is especially useful during respiratory infections, allergen exposure, or other flare triggers. Every patient with asthma, especially moderate or severe, should leave their visit with a personalized asthma action plan. [1,2]

Asthma Action Plan

An asthma action plan is personalized and color-coded that helps patients recognize changes in their breathing and know exactly what to do. It supports daily self-management and outlines when to seek help. Refer to the **Asthma Action Plan Zones Chart** below for corresponding symptoms: [3]

Green Zone (Controlled)	• No changes needed. • **Continue maintenance medications/therapy and regular follow ups**
Yellow Zone (Worsening Symptoms)	• Increased cough, wheezing, using rescue inhaler more • **Increase inhaler use, consider a short course of oral steroids if no improvement**
Red Zone (Severe Exacerbation)	• Struggling to breathe, peak flow <50% • **Seek emergency care immediately**

Asthma Action Plan Zones

Controlled	Worsening Symptoms	Severe
• No symptoms • No difficulty doing normal activities • Sleeping through the night • Using quick-relief inhaler less than 2 times per week - ***Take daily controller inhalers as prescribed*** • Use albuterol before exercise if directed • Avoid known triggers • **Continue monitoring symptoms regularly**	• Waking at night from asthma • Needing quick-relief inhaler more than usual • Some trouble doing usual activities - ***Use albuterol 2–4 puffs every 4–6 hours as needed*** • Continue controller inhalers • Monitor symptoms and/or peak flow • **Contact provider if no improvement in 24–48 hrs**	• Can't talk in full sentences • Lips or fingernails turning blue • Quick-relief inhaler not helping • Peak flow <50% of personal best **- *Use albuterol right away*** • Take oral corticosteroid if prescribed • **Go to the ER or call 911 immediately** • Do not wait to get help; this is no longer a warning- **it's an emergency**

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Asthma Action Plan

An asthma sick day plan outlines steps for managing asthma during illness, flare-ups, or exposure to triggers. It helps patients recognize early warning signs and respond quickly to prevent severe attacks. This plan should be reviewed regularly and adjusted based on each patient's baseline control and treatment regimen.

Sick Day Management Guide:[2]

Symptom Change or Situation	Recommended Action
Early signs of a flare-up (cough, fatigue, chest tightness)	1. Increase albuterol to 2–4 puffs every 4–6 hours 2. Continue controller inhalers 3. Monitor closely
Symptoms persist after 24–48 hours of albuterol	1. Contact clinic 2. Review meds 3. Consider prednisone if part of the care plan
Difficulty tracking symptom changes	1. Use a peak flow meter (if available) to monitor for decline 2. Log results
Waking at night due to symptoms	1. Add extra albuterol doses as needed 2. Check with provider if this continues
Uncertainty about how bad things are	1. Don't wait, call the provider to discuss your symptoms and next steps
Need for albuterol more than every 4 hours	1. Contact clinic promptly 2. You may be entering a more serious flare-up
Breathing is worsening or symptoms are severe	1. Use albuterol 2. Take oral steroids, if prescribed 3. Go to ER or call 911

Asthma Treatment

According to the Global Initiative for Asthma, asthma should be managed as a continuous cycle of assessment, treatment, and follow-up. This cycle allows providers to tailor care based on how well the patient is responding to treatment, their symptom burden, and risk of future exacerbations.[1]

Asthma Management

Asthma care should follow a structured process similar to COPD's "Review and Adjust" model, emphasizing regular reassessment. The GINA guidelines support this approach with the following framework: [3]

Diagnosis		
• Confirm asthma with spirometry ($FEV_1/FVC < 0.75–0.80$ and reversible with bronchodilator)		• Rule out other conditions
Initial Assessment		•
• Assess severity	• Assess risk factors and comorbidities (e.g., allergies, GERD, obesity)	• Assess symptom frequency
Initial Management		•
• Start therapy based on severity	• Educate on inhaler technique, develop an asthma action plan	• Identify triggers
Review		•
• Monitor symptom control	• Inhaler Technique & Adherence	• Lung Function
Adjust & Review (as needed) *		
• Step up or down as needed based on control	• Reinforce education, update action plans, and manage comorbidities	

* *Continue regular assessments to maintain control and prevent exacerbations.*

Recommended Vaccinations for Asthma Patients[2]

Recommended Vaccinations:	
• Influenza Vaccine	• COVID-19 Vaccine
• Pneumococcal Vaccine	• Tdap (dTap/dTPa)
• RSV Vaccine for individuals over ≥60 years at higher risk of RSV-related lower respiratory tract disease	

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Initial Pharmacological Treatment Recommendations: [1]

GINA recommends a stepwise approach to treatment based on symptom frequency and severity:

Steps	Clinical Indicators	Treatment Approach	Alternative/Optional Treatment
Step 1	Infrequent symptoms (less than 2x/month), no exacerbation risk	As-needed low-dose ICS-formoterol for infrequent symptoms	Low-dose ICS taken whenever SABA is used
Step 2	Symptoms more than 2x/month but less than daily	Daily low-dose ICS or as-needed ICS-formoterol	LTRA (e.g., montelukast) or low-dose ICS taken PRN
Step 3	Symptoms most days, or waking at night ≥1x/week	Low-dose ICS-LABA maintenance therapy	Medium-dose ICS or low-dose ICS + LTRA
Step 4	Daily symptoms, waking at night, limited activity	Medium-dose ICS-LABA	Add LAMA or consider specialist referral
Step 5	Symptoms persist despite Step 4 or severe exacerbations	High-dose ICS-LABA with referral for add-on therapies	Add-on biologic (e.g., anti-IgE, anti-IL5/IL4) or LAMA

Please Note:

- Controller medications should be adjusted by control level, not fixed to age or diagnosis time.
- As-needed ICS–formoterol is both a reliever and controller at Steps 1–3.
- Biologic therapies are considered at Step 5 for severe eosinophilic or allergic asthma.

Supportive & Palliative Care in Asthma: [1]

Unlike COPD, palliative or end-of-life care is not typically indicated in asthma. However, in rare cases of severe, treatment-resistant asthma, elements of supportive care (e.g., symptom relief, anxiety management) may be appropriate. Hospice is generally not applicable in asthma due to its reversible and controllable nature when managed appropriately.[1]

Confounders to Consider in a Patient with Suspected Asthma: [1]

If asthma is suspected but symptoms are atypical or unresponsive to standard therapy, consider alternative or coexisting diagnoses. Misdiagnosis is common in both adults and children.

Condition	Diagnostic Approach
Chronic Obstructive Pulmonary Disease (COPD)	• Mid-Life Onset • Smoking History • Persistent Airflow Limitation
Vocal Cord Dysfunction	• Inspiratory Stridor • Tight Throat • Poor Response to Bronchodilators
Heart Failure	• Orthopnea • PND • Elevated BNP • Fluid Overload
Gastroesophageal Reflux Disease (GERD)	• Heartburn • Regurgitation • Worsens When Lying Down
Obstructive Sleep Apnea	• Snoring • Daytime Fatigue • Obesity
Anxiety or Panic Disorder	• Chest Tightness • Dyspnea With Normal Lung Function

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Asthma Coding

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Asthma and Risk Adjustment

Accurate documentation of asthma severity is crucial for proper risk adjustment and calculating Risk Adjustment Factor (RAF) scores. RAF scores are used to predict healthcare costs and ensure appropriate reimbursement. Under-documentation can lead to underestimation of a patient's risk profile, affecting care management and funding.

Why It Matters

- Persistent asthma increases a patient's clinical risk profile
- Contributes to RAF scores under Medicare Advantage & ACA plans
- Helps align care management and reimbursement with patient complexity

Documentation Tips

Accurate and detailed documentation is critical for capturing the full severity of Asthma and ensuring appropriate risk adjustment. Below are key documentation points to improve coding accuracy and optimize risk adjustment:

✓ Specify Asthma Severity and Type; Use Terms Like:

- mild intermittent
- moderate persistent
- severe persistent

✓ Note Exacerbations:

- Document any recent asthma attacks
- Document any recent hospitalizations

✓ Detail Treatment Plans:

- Include current medications
- Include dosages
- Include patient adherence

✓ Avoid Ambiguity:

- Refrain from using vague term
- be specific in your descriptions

HCC Risk Adjustment Model

Asthma is usually a lifelong, chronic illness for most individuals. It may begin in childhood or be the result of one's work environment, one's social habits (smoking), exercise induced, or seasonal changes. Asthma is often under-diagnosed, especially in certain socio-economic regions and countries. Untreated asthma may cause poor concentration, lethargy, and sleep disturbances. Severe asthma can be fatal.

It depends on which risk adjustment payment model a patient falls into as to whether the diagnosis risk adjusts. In this document, we will focus on those that are part of the CMS HCC (Medicare) and the HHS HCC (commercial) risk adjustment models.

CMS – HCC Risk Adjustment Model

In the Medicare/Medicare Advantage risk adjustment model, only diagnoses (ICD10s) that fall into HCC 279 risk adjust or carry a risk adjustment factor value (RAF). The HCC group and RAF score are as follow:

HCC279	Severe Persistent Asthma	0.818

The diagnoses in this category are:

J45.50	Severe persistent asthma, uncomplicated	279
J45.51	Severe persistent asthma with (acute) exacerbation	279
J45.52	Severe persistent asthma with status asthmaticus	279

The mild and moderate asthma diagnosis codes are still very important for providers to use when appropriate for their patient. Yet it is important to know that they do not add a RAF value to the patient's complexity on the CMS risk adjustment model.

HHS– HCC Risk Adjustment Model

The HHS HCC risk adjustment model differs from the CMS HCC model in several ways. First, this model is a concurrent review, versus the CMS HCC model which is retrospective. Second, this model has adult, pediatric, and infant breakdown of RAF scores. And finally, the model has varying RAF values based on which level the patient/member's insurance falls into. The values shown immediately below are for the adult silver plan for the 2025 Benefit Year.

HCC 161_1	Severe Asthma	0.491
HCC 161_2	Asthma, Except Severe	0.491

The diagnoses in these categories are:

J45.20	Mild intermittent asthma, uncomplicated	HCC 161_2
J45.21	Mild intermittent asthma with (acute) exacerbation	HCC 161_2
J45.22	Mild intermittent asthma with status asthmaticus	HCC 161_2
J45.30	Mild persistent asthma, uncomplicated	HCC 161_2
J45.31	Mild persistent asthma with (acute) exacerbation	HCC 161_2
J45.32	Mild persistent asthma with status asthmaticus	HCC 161_2
J45.40	Moderate persistent asthma, uncomplicated	HCC 161_2
J45.41	Moderate persistent asthma with (acute) exacerbation	HCC 161_2
J45.42	Moderate persistent asthma with status asthmaticus	HCC 161_2
J45.50	Severe persistent asthma, uncomplicated	HCC 161_1
J45.51	Severe persistent asthma with (acute) exacerbation	HCC 161_1
J45.52	Severe persistent asthma with status asthmaticus	HCC 161_1
J45.901	Unspecified asthma with (acute) exacerbation	HCC 161_2
J45.902	Unspecified asthma with status asthmaticus	HCC 161_2
J45.909	Unspecified asthma, uncomplicated	HCC 161_2
J45.998	Other asthma	HCC161_2
J82.83	Eosinophilic asthma	HCC161_2

When documenting Asthma, remember to specify (if applicable):

- Document status of intermittent or persistent
- Document if asthma is mild, moderate or severe
- Also note if it is uncomplicated, acute exacerbation or status asthmaticus
- If present, clarify the relationship between COPD, bronchitis and asthma
- Unspecified asthma does not risk adjust in either model (J45.909). It is unspecified asthma, uncomplicated and includes childhood asthma not otherwise specified.
- Exercise induced bronchospasm (J45.990) is a common diagnosis in pediatrics and adolescents. Even though this diagnosis does not risk adjust, it too is very important for telling the most accurate story about the patient.
    - Note: Acute exacerbation is a worsening or decompensation of a chronic condition and *is not* equivalent to an infection superimposed on a chronic condition.

Provider documentation example:

HPI:

The pt is a 71-old-female who presents today for a hospital f/u. She was recently d/c'd from the hospital after having a severe asthma attack. The pt was in the ICU for 4 days on a ventilator for 3 days. She was d/c'd on O2 at 2L via NC. She monitors her O2 sats at home. The pt has audible wheezes and SOB with mild exertion. Her O2 sat today is 97% on 2L, and 91% on RA. Afebrile. This is not her first hospitalization for a severe asthma attack, and her pulmonologist continues to adjust her medications to stabilize her condition. The patient still c/o fatigue and a sore throat. She has a f/u with her pulmonologist, Dr. N next week.

A&P:

Severe persistent asthma, uncomplicated (J45.50)

Hypoxemia (R09.02)

Pt recently d/c from the hospital due to a severe asthma attack. Currently on O2 at 2L. Reviewed hospital images and notes. Pulmonology seeing patient next week and will determine if the patient is to remain on oxygen long term. Reassured patient that sore throat will improve and most likely secondary to ET tube. Recommend throat lozenges for comfort.

- *Note:* Long term oxygen dependence not coded, for the patient has only been on it short term, and it is unclear at this time if the patient is in respiratory failure due to her asthma.

Coder specific guidelines:

The J45 Asthma group includes:

- Allergic (predominantly) asthma
- Allergic bronchitis NOS
- Atopic asthma
- Extrinsic allergic asthma
- Hay fever with asthma
- Idiosyncratic asthma
- Nonallergic asthma

Use additional codes to denote exposure to or use of tobacco and eosinophilic asthma. For example:

- Exposure to environmental tobacco smoke (Z77.22)
- Exposure to tobacco smoke in the perinatal period (P96.81)
- History of tobacco dependence (Z87.891)
- Occupational exposure to environmental tobacco smoke (Z57.31)
- Tobacco dependence (F17.-)
- Tobacco use (Z72.0)
- Eosinophilic asthma (J82.83) – which is an HCC group in the HHS RA model.

Do not forget the Excludes1 and Excludes2 notes when appropriately reviewing and coding asthma.

Excludes1 note: Not allowed to be coded together with any of the diagnosis codes listed below:

- Detergent asthma (J69.8)
- Miner's asthma (J60)
- Wheezing NOS (R06.2)
- Wood asthma (J67.8)
- Bronchitis due to chemical/gases/fumes/vapors (J68.0)

Excludes2 note: Allowed to be coded with the diagnosis codes listed below, if applicable and documented by the clinician.

- Asthma with COPD (J44.9)
- Chronic asthmatic (obstructive) bronchitis (J44.9)
- Chronic obstructive asthma (J44.9)
- Cystic fibrosis (E84.-)

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Asthma in Special Populations & Triggers

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Asthma in Special Populations

Asthma affects people of all ages but presents unique challenges depending on age and life stage. Treatment must be individualized to reflect risk, comorbidities, and care goals.

Children

Asthma is prevalent among children, with approximately 4.9 million affected in the U.S. Environmental factors, such as air pollution and allergens, significantly impact pediatric asthma. Early diagnosis and management are vital to prevent long-term complications. Diagnosing asthma in young children is largely clinical, based on recurrent wheezing, coughing, symptom patterns, and response to bronchodilators. Objective testing like spirometry is typically not feasible under age 5.[4,5]

Key Considerations: [5]

- Clinical diagnosis in children under 5 is based on symptoms, response to bronchodilators, and exclusion of other conditions.
- Viral respiratory infections are the most frequent exacerbation triggers.
- The Asthma Predictive Index (API) helps estimate long-term risk of persistent asthma.
- Low-dose inhaled corticosteroids (ICS) are first-line therapy for persistent symptoms.
- Spacers with masks improve medication delivery in young children.
- Involve families in asthma education and action planning early.

Older Adults[1]

In older adults, asthma may be underdiagnosed or misdiagnosed as COPD. Age-related changes in lung function and the presence of comorbidities can complicate diagnosis and treatment. Comprehensive assessment is essential for accurate diagnosis and effective management.

Other Populations: [1,4,5]

Population	Key Element	Management Considerations
Children	High incidence under age 18; often triggered by viral infections, allergens, or activity	Educate caregivers; develop school asthma plans; avoid over diagnosing under age 5
Adolescents	May be poorly adherent; psychosocial issues, smoking, vaping risks	Self-management education; assess for inhaler technique and medication adherence
Pregnant Patients	Asthma may improve, worsen, or stay stable during pregnancy	Continue controller meds; avoid stopping ICS; close OB-Pulmonology coordination
Older Adults	May overlap with COPD; often underdiagnosed due to symptom misattribution	Use spirometry; distinguish from heart failure or COPD; review polypharmacy and comorbidities

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Environmental Triggers in Asthma

Environmental exposures are major contributors to asthma onset and control, particularly in children. Managing these exposures is a critical component of asthma care in both home and school environments.

Common Triggers and Management: (2)

Trigger	Examples	Strategies
Allergens	Dust mites, pet dander, mold, pollen	Allergen-proof bedding, HEPA filters, frequent cleaning
Air Pollution	Wildfire smoke, ozone, vehicle exhaust	Limit outdoor activity on high AQI days, air purifiers
Tobacco Smoke	Firsthand, secondhand, thirdhand	Promote smoke-free homes/cars, refer to cessation support
Indoor Irritants	Scented candles, cleaners, cooking fumes	Use fragrance-free/low-VOC products, ventilate space
Weather Changes	Cold, dry air or rapid temp changes	Use scarves/masks outdoors, pre-treat with bronchodilator

Smoking Cessation

Smoking Cessation in Asthma

Quitting smoking is one of the most important interventions for people with asthma. Tobacco smoke (including e-cigarettes and secondhand smoke) worsens inflammation, increases asthma attacks, decreases lung function, and reduces the effectiveness of inhaled corticosteroids. Stopping smoking improves asthma control, reduces medication use, and prevents long-term lung damage. [1,3]

How to Talk About Quitting (The 5 A's Approach):

ASK	*"Do you currently smoke or use any tobacco products? "*
ADVISE	*"Quitting is the best way to protect your lungs and get better asthma control."*
ASSESS	*"Are you interested in trying to quit?"*
ASSIST	Provide medication, behavioral support, and referrals.
ARRANGE	Follow up to support progress and prevent relapse.

Smoking Cessation Treatments:

Medication	Length of treatment/dose	Coverage
Bupropion ER (SR) (Zyban)	150mg orally once daily for 3 days, then 150mg orally twice daily for a total of 12 weeks	**BMA:** YES **Medicaid:** YES **Banner Aetna:** YES
Nicotine OTC (Nicorette, NicoDerm)	**Gum** – least expensive General dose is 2mg, unless the first cigarette is used within 30 minutes of waking; then use 4mg Weeks 1-6: chew 1 piece every 1-2 hrs; max of 24pcs/day Weeks 7-9: chew 1 piece every 2-4 hrs; max of 24 pcs/day Weeks 10-12: chew 1 piece every 4-8 hrs; max of 24 pcs/day	**BMA:** NO (OTC) **Medicaid:** YES **Banner Aetna:** Copay exception*
	Lozenge General dose is 2mg, unless the first cigarette is used within 30 minutes of waking; then use 4mg Weeks 1-6: use 1 lozenge every 1-2 hours (max of 5 lozenges/6 hours; 20 lozenges/day) Weeks 7-9: use 1 lozenge every 2-4 hours (max of 5 lozenges/6 hours; 20 lozenges/day) Weeks 10-12: use 1 lozenge every 4-8 hours (max of 5 lozenges/6 hours; 20 lozenges/day)	
	Patch Patients smoking >10 cigarettes/day: use 21mg patch/day for 6 weeks, then 14mg patch/day for 2 weeks, then 7mg patch/day for 2 weeks Patients smoking <10 cigarettes/day: use 14mg patch/day for 6 weeks, then 7mg patch/day for 2 weeks	
Nicotine Rx only (Nicotrol)	**Nasal Spray** Dose = 1 spray in each nostril (1mg of nicotine);1-2 doses/hour, no more than 5 doses per hour (max 40mg/day) for 4-6 weeks Adjustments in dose may be done based on the patient	**BMA:** YES **Medicaid:** YES **Banner Aetna:** copay exception**
Varenicline (Chantix)	**Starter** Days 1-3: 0.5mg orally once daily Days 4-7: 0.5mg orally twice daily **Maintenance** 1mg orally twice daily for 11 weeks- total treatment for 12 weeks	**BMA:** YES **Medicaid:** YES **Banner Aetna:** YES

**Copay exception indicates that it is available to members with a prescription when visiting an in-network provider and pharmacy*

***Always consider individual health history and asthma severity when choosing medications*

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Best Practices Considerations: (2)

- Ask about tobacco use at every visit, even if patients only vape or occasionally smoke
- Explain how smoking worsens asthma control and reduces inhaler effectiveness
- Encourage combination therapy (medications + behavioral support)
- Follow up regularly. Relapse is common, but each attempt builds momentum

Resources

Arizona Smokers' Helpline (ASHLine) sponsored by the Arizona Department of Health Services and Prevention Program (AZDHS-TEPP) offers no cost service to support you. It can also help you set a quit date. If you would like more information about quitting tobacco:

- Call: 1-800-55-66-222
- Text: "START MY QUIT" to 300500
- Visit: https://www.azdhs.gov/ashline/

Other Helpful Sites:

- CDC Tips From Former Smokers
- American Lung Association – Quit Smoking

Emergency & Hospitalization Prevention

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Emergency and Hospitalization Prevention

Uncontrolled asthma leads to ED visits and avoidable hospitalizations. Primary care can help reduce these risks through proactive monitoring, education, and timely treatment adjustments. Preventing asthma-related hospitalizations involves a multifaceted approach: [1,3]

- **Patient Education:** Ensure patients understand their condition and treatment plan.
- **Medication Adherence:** Encourage consistent use of prescribed medications.
- **Regular Monitoring:** Use tools like peak flow meters to monitor lung function.
- **Trigger Management:** Identify and minimize exposure to asthma triggers.
- **Follow-Up Care:** Schedule regular check-ups to adjust treatment as needed.

Hospitalization Risk Reduction Strategies: [2]

Intervention	Approach
Asthma Action Plan	Should be documented in the chart and reviewed annually
Follow-up after ER visit	Schedule within 1 week of ER/hospitalization; reassess severity and adherence
Controller medication use	Track refill rates and technique to ensure correct daily ICS or ICS-LABA use
Trigger management	Address environment: allergens, smoke, mold, work exposures
Vaccinations	Flu, pneumococcal, and COVID-19 vaccines reduce infection-related exacerbations
Care coordination	Refer to pulmonology or case management for frequent exacerbators or poorly controlled patients

Asthma Education and Resources

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Asthma Action Plan

Provider: _____ Clinic: _____

American Lung Association.

My Asthma Action Plan

Name: _____ DOB: ____ / ____ / _____

Severity Classification: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Asthma Triggers (list): _____

Peak Flow Meter Personal Best: _____

Green Zone: Doing Well

Symptoms: Breathing is good – No cough or wheeze – Can work and play – Sleeps well at night
Peak Flow Meter _____ (more than 80% of personal best)

Flu Vaccine—Date received: _____ Next flu vaccine due: _____ COVID19 vaccine—Date received: _____

Control Medicine(s)	Medicine	How much to take	When and how often to take it

Physical Activity ☐ Use Albuterol/Levalbuterol ____ puffs, 15 minutes before activity
☐ with all activity ☐ when you feel you need it

Yellow Zone: Caution

Symptoms: Some problems breathing – Cough, wheeze, or tight chest – Problems working or playing – Wake at night
Peak Flow Meter _____ to _____ (between 50% and 79% of personal best)

Quick-relief Medicine(s) ☐ Albuterol/Levalbuterol ____ puffs, every 20 minutes for up to 4 hours as needed
Control Medicine(s) ☐ Continue Green Zone medicines
☐ Add _____ ☐ Change to _____

You should feel better within 20-60 minutes of the quick-relief treatment. If you are getting worse or are in the Yellow Zone for more than 24 hours, THEN follow the instructions in the RED ZONE and call the doctor right away!

Red Zone: Get Help Now!

Symptoms: Lots of problems breathing – Cannot work or play – Getting worse instead of better – Medicine is not helping
Peak Flow Meter _____ (less than 50% of personal best)

Take Quick-relief Medicine NOW! ☐ Albuterol/Levalbuterol ____ puffs, _____ (how frequently)

Call 911 immediately if the following danger signs are present:
- Trouble walking/talking due to shortness of breath
- Lips or fingernails are blue
- Still in the Red Zone after 15 minutes

Emergency Contact Name _____ Phone (____) _____ - _____

Date: ____ / ____ / _____

1-800-LUNGUSA | Lung.org

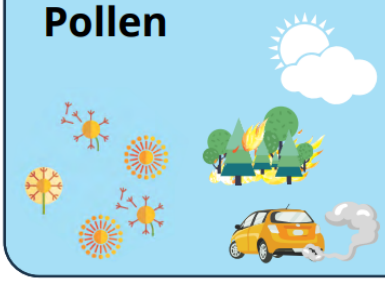
ALA Asthma AP V4 3 1 2023

These guidelines serve to assist in the management, documentation, and coding of clinical diagnoses. The intent of this document is to supplement, but not replace, the provider's clinical judgement.

Asthma Triggers

Outdoor Triggers

Weather
Air Quality
Pollen

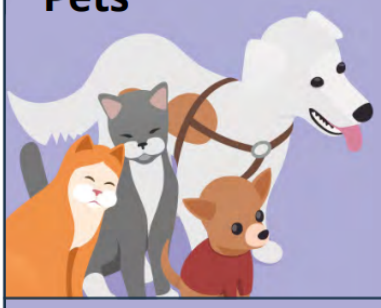


- Pay attention to radio, television, the internet, or newspaper reports about things that might trigger your asthma. These might include reports about weather, air quality, pollen count, or wildfire conditions.
- Plan outdoor activities for when the air quality is best.
- If pollen triggers your asthma, close windows and turn on air conditioning (if possible) when pollen levels are high.
- When there are wildfires, stay away from areas where there is smoke or vapors. Stay indoors, if possible, to avoid smoke or vapors.
- When it is cold, wear a scarf or face mask that covers your nose and mouth to keep airflow as warm as possible.

Indoor Triggers

If you are allergic to dust mites, cockroaches, rodents, indoor mold, or pets, use an air purifier with a high-energy particulate air (HEPA) filter, and use HEPA filters for vacuum cleaners. Keep your home as clean as possible. If you can, ask someone else to clean your home regularly, or wear a dust mask while you clean.

Pets



If you are allergic to your pet, the best way to avoid exposure is to remove the pet from your home and have the house cleaned. If you can't remove the pet:

- Keep the pet out of your bedroom.
- Ask a family member to wash your pet regularly.
- Use allergen-proof pillow and mattress covers.
- Use an air cleaner with HEPA filter.

Note: Pet fur, skin, and saliva trigger some people's asthma.

Dust mites
(tiny bugs that live in dust and fabric)

- Keep relative humidity levels in your home low, around 30%–50%.
- Wash your bedding every week and dry completely.
- Use allergen-proof pillow and mattress covers.

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Asthma Triggers

Indoor Triggers

Cockroaches **Mice** **Rats** 	• Keep your kitchen clean and store food and garbage in closed containers. • Don't leave out any standing water or other liquids. • Seal cracks or openings in cabinets, walls, floorboards, and around plumbing. • Use traps or poison bait to get rid of roaches, mice, or rats. Keep bait away and out of reach of children and pets. Avoid sprays and foggers.
Mold **Humidity** 	• Fix water leaks as soon as possible and dry damp or wet items within 48 hours. • Remove all moldy items from your home. • Use an air conditioner or dehumidifier to keep the air dry in your home. Keep relative humidity levels in your home low, around 30%–50%. • Empty and clean refrigerator and air conditioner drip pans regularly. • Use bathroom exhaust fans or open windows when you shower.
Smoke **Sprays** **Scents** **Disinfectants** 	• Avoid places where people smoke. If you smoke, ask your healthcare provider how to quit. • Don't use a wood-burning stove, kerosene heater, or fireplace. • Avoid perfume, paint, hairspray, and talcum powder. • Try to stay away when cleaners or disinfectants are being used and right after their use. • Increase air flow by opening doors and windows and turning on exhaust fans.

Other Common Triggers

Illness 	• Contact your healthcare provider if you think you have another health problem that is making it harder for you to breathe. Such problems might include the flu, a cold, acid reflux (heartburn), a sinus infection, severe allergies, or another health concern.
Emotions 	• Talk to your healthcare provider if anxiety, stress, or other emotions make your asthma worse.

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Care Management

Banner Plans & Networks

CARE MANAGEMENT REFERRAL FORM

Completed Medical Forms can be sent to:
Fax: 480-655-2537 or Email: BHNPopHealthManagement@BannerHealth.com

Please send Maternal Health or Behavioral Health referrals to:
Behavioral: BUHPCareMgmtBHMailbox@bannerhealth.com Maternal Health: BUHPMaternalChildHealth@bannerhealth.com

Appropriate stabilization of EMERGENT medical or behavioral health concerns shall be initiated through proper emergency or crisis services channels, BEFORE submitting Care Management Referrals. Care Management will outreach to the member within 24 business hours.

Referral Date: _____

Member Information	Referral Information
Primary Health Plan: Please Select	Requested By: _____
Additional Insurances *(If Any)*: _____	Requester Name: _____
Name _____	Phone: _____
Address: _____	
ID #: _____ DOB: _____	Diagnosis: _____
Phone: _____ Language: _____	PCP: _____

Reason(s) for Care Management Request

MEDICAL

- ☐ General Medical Issues *(ex: Member needs help understanding their diseases, coordinating care with their doctors, etc.)*
- ☐ High or Inappropriate medical utilization *(ex: frequent ER visits, frequent PCP changes, medication management issues)*
- ☐ Post Discharge Assistance for continued care management support
- ☐ Medication Assistance *(ex: education, cost barriers, adherence, and polypharmacy)*
- ☐ Chronic condition / Newly diagnosed condition*(s)* *(specify below)*
- ☐ Non-adherence to PCP treatment plan, missed appointments and/or annual screening
- ☐ High Priority Transplant, HIV, Hemophilia member requesting assistance
- ☐ Interdepartmental Medical Management request for immediate assistance
- ☐ Maternal Child Health – Pregnant, Postpartum (up to 1 year after delivery), Pediatric *(under age 21)*, and CRS
- ☐ Dial Into Diabetes Program – Diabetic Care Management
- ☐ Home Safety Concerns
- ☐ Advance Directive / End of Life Planning
- ☐ Community Resources *(ex: financial needs, transportation, caregiver support, support groups)*
- ☐ ALTCS ONLY – Refer to assigned CM / RN
- ☐ Other *(specify below)*

BEHAVIORAL

- ☐ Routine BH referrals *(ex: member requests advocacy for Behavioral Health or indicates need for BH assistance in some way that is not urgent or related to inpatient and/or medication)*
- ☐ Member / Family member has questions about BH services, how to access covered services, complaints, etc.
- ☐ Suicidal / Homicidal caller. *(Please refer **AFTER** you follow SI/HI protocol)*
- ☐ Member requests referral for BH services *(ex: therapy, groups, etc.)*
- ☐ Mental Health needs *(ex: Dementia, Alzheimer's, depression, substance abuse)*
- ☐ Urgent need for psychotropic medication
- ☐ ALTCS ONLY – Refer to assigned CM/RN
- ☐ Other *(specify below)*

Details Relating to Reason for Referral and Additional Comments ***(What happened? What do you want done?)***

Rev: 1/8/2024 (ECT)

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Asthma Ashline – Arizona Smokers' Helpline

Arizona Smoker's Ashline

HOW THE ASHLINE WORKS

When you call us at 1-800-55-66-222, we match you with a Quit Coach who will help you develop a personalized plan to quit tobacco.

As part of your Quit Plan, you'll decide with your coach the best time and the best way to connect.

With your Quit Coach, you will make plans for things like picking a day to stop using tobacco, learning how to deal with cravings, and figuring out what to do if quitting gets tough.

WHEN MAKING A QUIT PLAN, YOU AND YOUR QUIT COACH WILL:

- Talk about how ready you are to quit
- Discuss why you want to stop using tobacco
- Decide when to meet with your coach next

DID YOU KNOW?

The benefits of quitting tobacco begin right away. Here's what happens to your body after you quit smoking:

- Minutes after quitting, your heart rate drops
- After 24 hours, nicotine levels in the blood drop to zero
- After 1 to 12 months, coughing and shortness of breath decrease
- After 1 to 2 years, risk of heart attack drops
- After 5 to 10 years, risk of certain cancers drops by half

CALL 24/7 TO GET STARTED

1-800-55-66-222

or text "start my quit" to 300500 today!

www.ASHLine.org

ASH LINE

Arizona Smokers' Helpline

START YOUR TOBACCO QUIT JOURNEY TODAY!

Everyone's reasons for quitting tobacco are different. Call the Arizona Smokers' Helpline to get help from a professional Quit Coach.

Call 1-800-55-66-222 or text "start my quit" to 300500

Visit ASHLine.org for more information

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Appendix

Banner Health Network

Population Health Services Organization

ASTHMA - COPD

The information below is a sample of commonly used medications and not an all inclusive list of medications covered by the various health plans. This information is valid only for 2025 and is subject to minor changes throughout the year.

Tier applies to generic product unless * * = Only Brand name available ST = Step Therapy PA= Prior Authorization Required NF = Non Formulary PA BvD = Prior Authorization for Part B vs Part D Determination	Banner|Aetna (Banner Employee) 2025	Banner Med Adv HMO 2025	Banner Med Adv Dual 2025	BCBS Med Adv 2025	United Med Adv 2025	Humana Med Adv 2025	Aetna Med Adv 2025
Short-Acting Bronchodilators							
albuterol inh susp (ProAir, Ventolin HFA)	Tier 1/$0	Tier 2	Tier 1/$0	Tier 2	Tier 2	Tier 3	Tier 2
albuterol inh pwdr (ProAir Respiclick)*	NF	NF	NF	Tier 3	NF	NF	NF
albuterol **Nebulizer**	Tier 1/$0	Tier 2 PA BvD	Tier 1 PA BvD	Tier 2 BvD	Tier 2 PA BvD	Tier 2 BvD	Tier 2 BvD
ipratropium (Atrovent HFA)*	NF	Tier 4	Tier 1/$0	Tier 4	Tier 4	Tier 4 PA	Tier 4
ipratropium soln **Nebulizer**	Tier 1/$0	Tier 2 PA BvD	Tier 1 PA BvD	Tier 2 BvD	Tier 2 PA BvD	Tier 2 BvD	Tier 2 BvD
ipratropium/albuterol (DuoNeb)	Tier 1/$0	Tier 2 PA BvD	Tier 1 PA BvD	Tier 2 BvD	Tier 1 PA BvD	Tier 2 BvD	Tier 2 BvD
levalbuterol hfa (Xopenex HFA)	Tier 1	NF	NF	Tier 3	Tier 3	Tier 4 ST	Tier 3
levalbuterol **Nebulizer**	Tier 1	NF	NF	Tier 4 BvD	Tier 4 PA BvD	NF	Tier 2 BvD
Long-Acting Bronchodilators / Anticholinergics							
aclidinium (Tudorza)*	NF	NF	NF	NF	NF	NF	NF
arformoterol (Brovana)	Tier 1	Tier 4 PA BvD	Tier 1 PA BvD	Tier 4 PA	Tier 4 PA BvD	Tier 4 BvD	NF
formoterol soln (Perforomist)	Tier 1	Tier 4 PA BvD	Tier 1 PA BvD	Tier 4 BvD	Tier 4 PA BvD	NF	NF
indacaterol (Arcapta)*	NF	NF	NF	NF	NF	NF	NF
olodaterol (Striverdi Respimat)*	Tier 2	Tier 3	Tier 1/$0	NF	NF	Tier 3	NF
revefenacin solution (Yupelri)*	Tier 2	NF	NF	Tier 5 BvD	NF	NF	NF
salmeterol (Serevent)*	NF	NF	NF	Tier 3	Tier 3	NF	Tier 3
tiotropium (Spiriva)*	Tier 2	Tier 3	Tier 1/$0	Tier 4	Tier 3	Tier 3	NF
umeclidinium (Incruse Ellipta)*	NF	NF	NF	Tier 3	Tier 3	NF	Tier 3
Inhaled Corticosteroids							
beclomethasone (Qvar/Qvar Redihaler)*	NF	Tier 3	Tier 1/$0	Tier 3	Tier 3	NF	NF
budesonide (Pulmicort Flexhaler)*	Tier 2/$0	NF	NF	NF	NF	NF	NF
budesonide inh susp **Nebulizer** (Pulmicort Respules)	Tier 1	Tier 4 PA BvD	Tier 1 PA BvD	Tier 4 BvD	Tier 4 PA BvD	Tier 4 BvD	Tier 4 BvD
flunisolide 80mcg (Aerospan)	NF	Tier 3	Tier 1/$0	NF	Tier 1	NF	NF
fluticasone (Flovent HFA)	NF	Tier 4 ST	Tier 1/$0	NF	NF	NF	NF
fluticasone furoate (Arnuity Ellipta)*	NF	NF	NF	Tier 3	Tier 3	Tier 3	Tier 3
mometasone (Asmanex HFA/Twisthaler)*	Tier 2	Tier 3	Tier 1/$0	Tier 4	NF	NF	NF
Leukotriene Antagonists							
montelukast **Tablets** (Singulair)	Tier 1/$0	Tier 1/$0	Tier 1/$0	Tier 1	Tier 1	Tier 1	Tier 1
montelukast **Chewable Tablets** (Singulair)	Tier 1/$0	Tier 2	Tier 1/$0	Tier 2	Tier 1	Tier 1	Tier 1
zafirlukast (Accolate)	Tier 1	Tier 4	Tier 1/$0	Tier 4	Tier 3	Tier 4	Tier 4
zileuton (Zyflo)*	NF	NF	NF	NF	NF	NF	NF
Combination Products							
albuterol/budesonide (Airsupra)*	Tier 2	NF	NF	NF	NF	NF	NF
budesonide/glycopyrrolate/formoterol fumarate (Breztri Aerosphere)*	NF	Tier 3	Tier 1/$0	Tier 3	Tier 3	Tier 3	Tier 3
fluticasone-salmeterol **Breath Activated** 100-50mcg, 250-50mcg, 500-50mcg (Advair Diskus)	Tier 1/$0	Tier 3	Tier 1/$0	Tier 2	Tier 3	Tier 3	Tier 2
fluticasone-salmeterol **Inhaler** 45-21mcg, 115-21mcg, 230-21mcg (Advair HFA)*	NF	Tier 3	Tier 1/$0	Tier 3	NF	Tier 3	Tier 4
fluticasone-salmeterol **Inhaler** 55-14mcg, 113-14mcg, 232-14mcg (AirDuo Respiclick)	NF	NF	NF	NF	NF	Tier 3	NF
fluticasone-salmeterol **Breath Activated** 100-50mcg, 250-50mcg, 500-50mcg (Wixela Inhub)*	Tier 1/$0	Tier 3	Tier 1/$0	Tier 2	Tier 3	Tier 3	Tier 2
fluticasone-vilanterol (Breo Ellipta)*	NF	Tier 3	Tier 1/$0	Tier 3	Tier 3	Tier 3	Tier 3
fluticasone-umeclidinium-vilanterol (Trelegy Ellipta)*	Tier 2	Tier 3	Tier 1/$0	Tier 3	Tier 3	Tier 3	Tier 3
formoterol-budesonide (Symbicort)	Tier 1	Tier 3	Tier 1/$0	NF	Tier 3	Tier 3	Tier 3
glycopyrrolate-formeterol (Bevespi Aerosphere)*	Tier 2	Tier 3	Tier 1/$0	NF	Tier 3	NF	Tier 3
ipratropium-albuterol (Combivent Respimat)*	NF	Tier 3	Tier 1/$0	Tier 3	Tier 3	Tier 4	Tier 4
ipratropium-albuterol (DuoNeb)	Tier 1/$0	Tier 2 PA BvD	Tier 1 PA BvD	Tier 2 BvD	Tier 1 PA BvD	Tier 2 BvD	Tier 2 BvD
mometasone-formoterol (Dulera)*	NF	Tier 3	Tier 1/$0	Tier 4 PA	Tier 4	NF	Tier 4
tiotropium-olodaterol (Stiolto Respimat)*	NF	Tier 3	Tier 1/$0	Tier 3	Tier 3	Tier 3	NF
umeclidinium-vilanterol (Anoro Ellipta)*	Tier 2	NF	NF	Tier 3	Tier 3	NF	Tier 3
Other							
metaproterenol **Syrup**	NF	NF	NF	NF	NF	NF	NF
metaproterenol **Tablets**	NF	NF	NF	NF	NF	NF	NF
terbutaline subcutaneous	NF	Tier 2	Tier 1/$0	NF	NF	NF	NF
terbutaline oral	Tier 1	Tier 4	Tier 1/$0	NF	NF	NF	Tier 4
cromolyn **Nebulizer** (Intal)	Tier 1	Tier 3 PA BvD	Tier 1 PA BvD	Tier 3 BvD	Tier 3 PA BvD	Tier 3 PA BvD	Tier 2 BvD
theophylline oral liquid (Elixophyllin)	Tier 1	Tier 4	Tier 1/$0	NF	Tier 2	NF	Tier 2
theophylline ER (Theo-24)	Tier 1	Tier 2	Tier 1/$0	Tier 2	Tier 2	Tier 4	Tier 2
theophylline ER 12 hr oral tab	Tier 1	Tier 2	Tier 1/$0	Tier 4	Tier 2	Tier 4	Tier 4
glycopyrrolate nebulizer (Lonhala Magnair)*	NF	NF	NF	NF	NF	NF	NF
Biologics							
benralizumab (Fasenra)*	Tier 3 PA	Tier 5 PA	Tier 1 PA	Tier 5 PA	Tier 5 PA	Tier 5 PA	Tier 5 PA
dupilumab (Dupixent)*	Tier 3 PA	Tier 5 PA	Tier 1 PA	Tier 5 PA	Tier 5 PA	Tier 5 PA	Tier 5 PA
mepolizumab (Nucala)*	Tier 3 PA	Tier 5 PA	Tier 1 PA	Tier 5 PA	NF	Tier 5 PA	NF
omalizumab (Xolair)*	Tier 3 PA	Tier 5 PA	Tier 1 PA	Tier 5 PA	Tier 5 PA	Tier 5 PA	Tier 5 PA
reslizumab (Cinqair)*	NF	NF	NF	NF	NF	NF	NF

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- (3) Merck Manuals. Classification of asthma severity: https://www.merckmanuals.com/professional/multimedia/table/classification-of-asthma-severity
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Asthma Action Plan

- National Heart, Lung, and Blood Institute – Asthma Action Plan: https://www.nhlbi.nih.gov/health/asthma/treatment-action-plan
- CDC – Asthma Action Plan Resources: https://www.cdc.gov/asthma/actionplan.html

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- Global Initiative for Asthma (GINA) – 2023 Pocket Guide: https://ginasthma.org/wp-content/uploads/2023/07/GINA-2023-Pocket-Guide-WMS.pdf
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- NHLBI – 2020 Asthma Management Guidelines: https://www.nhlbi.nih.gov/health-topics/asthma

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- CMS 20205 Model ICD-10-CM-Mappings: https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics/risk-adjustment/2025-model-software/icd-10-mappings
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- CDC – Quit Smoking Resources: https://www.cdc.gov/tobacco/quit_smoking/index.htm
- American Lung Association – Quit Smoking Support: https://www.lung.org/quit-smoking

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- U.S. Department of Health & Human Services – Treating Tobacco Use and Dependence: https://www.ncbi.nlm.nih.gov/books/NBK63952/

Emergency & Hospitalization Prevention

- American Academy of Allergy, Asthma & Immunology – Asthma Treatment Overview: https://www.aaaai.org/conditions-and-treatments/asthma
- CDC – Asthma Guidelines and Self-Management Support: https://www.cdc.gov/asthma/guidelines.htm
- Global Initiative for Asthma (GINA) – Reducing Exacerbation Risk: https://ginasthma.org/

Links to Banner Education Resources:

- https://www.bannerhealth.com/calendar
- https://www.lung.org/lung-health-diseases/lung-disease-lookup/asthma/managing-asthma/reduce-asthma-triggers