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Luforbec 100/6 is indicated in the regular treatment of asthma in adults (>18 years) where use of a combination inhaled corticosteroid/long-acting beta₂ agonist (ICS/LABA) is appropriate. Luforbec 100/6 can be used as Maintenance and Reliever Therapy (MART) in appropriate adult asthma patients (>18 years).

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QUICK GUIDE

Moving beyond the blue inhaler: implementing asthma guidance in primary care

For decades, the short-acting beta₂ agonist (SABA) – the familiar blue inhaler – was the cornerstone of asthma management.^{1,2} That has now changed. The landmark November 2024 British Thoracic Society/National Institute for Health and Care Excellence/Scottish Intercollegiate Guidelines Network (BTS/NICE/SIGN) unified guideline marks a paradigm shift, one which cautions the overreliance on SABA, and instead frames new recommendations for combination inhaled corticosteroid (ICS)/formoterol inhalers, which relieve symptoms while also treating the airway inflammation that drives asthma.³

With these changes, ICS/formoterol (a long-acting beta₂ agonist) inhalers, used either as anti-inflammatory reliever (AIR) or maintenance and reliever therapy (MART), are now central to care for people aged 12 and over with varying degrees of asthma symptoms/severity.³ More than one million people in England are already using AIR or MART inhalers, overtaking those still relying on SABA alone.¹

This quick guide supports HCPs in understanding the

rationale for these changes, identifying patients who need review, and managing transitions in practice.

Why asthma management has changed

SABA inhalers offer bronchodilation for symptom relief, but they do not address the inflammation that is the underlying driver of asthma.² The NICE evidence review underpinning the guideline found that the poorest clinical outcomes across all age groups were seen in people using SABA alone, and national reviews of asthma deaths have highlighted the risks of prescribing SABA without ICS.³ If airway inflammation goes untreated, it can cause structural remodelling of the airways over time, making asthma progressively harder to control.⁴

Overuse of SABA is also of concern. In 2024 to 2025, nearly half (48%) of blue inhaler users in England were prescribed more than two in a single year, a threshold specialists regard as a warning sign.¹ Using three or more SABA inhalers per year is associated with increased accident and emergency (A&E) visits

Continued overleaf →

Figure 1 Key characteristics for AIR and MART

AIR
(Anti-Inflammatory Reliever)

AIR uses a low-dose ICS/formoterol inhaler as needed, without any regular maintenance therapy³

- It is recommended first-line for newly diagnosed asthma in patients aged ≥ 12 years³
- Only certain budesonide/formoterol dry powder inhalers (DPIs), i.e. no pressurised metered-dose inhalers (pMDIs), are licensed for AIR therapy in mild asthma³
- Doses can be taken as needed by the patient according to symptoms.³

MART
(Maintenance And Reliever Therapy)

MART uses a single ICS/formoterol inhaler as both regular daily maintenance and as a reliever whenever symptoms occur³

- MART is indicated where asthma is not controlled on AIR alone, or in those presenting initially with a higher symptom burden³
- MART offers the simplicity of a single device for both relief and maintenance. Patients already on an ICS/formoterol inhaler can step up to MART without needing to change device³
- Where asthma is subsequently well controlled on MART, stepping down to AIR-only therapy is appropriate.³

and hospital admissions, regardless of asthma severity, and SABA overuse is a common observation seen in national reviews of asthma-related mortality.² In addition, SABA can mask disease progression, leaving patients unaware of how poorly controlled their asthma is long-term.¹

AIR and MART: recommendations and optimised outcomes

The guideline introduces two ICS/formoterol-based treatment approaches, AIR and MART, as replacements for SABA monotherapy.³ Both use formoterol as the bronchodilator component,³ which has a rapid onset of action (1–3 minutes) and duration of up to 12 hours.⁵

Which asthma patients should be reviewed?

A review should begin with a thorough assessment of current symptom burden and asthma control, including frequency of symptoms, night waking and reliever use.³ SABA prescribing history and adherence to any existing maintenance therapy should be explored before any decision is made to adjust treatment.³ Inhaler technique should be checked and corrected before considering a switch to a new device, since poor technique is one of the most common and easily addressable causes of apparent treatment failure.^{3,7}

Proactive review of existing asthma patients includes the following high-risk populations³:

- those with a likelihood of non-adherence to medicines
- patients with a history of (and/or):
 - overuse of SABA inhalers (more than two inhalers per year)
 - two or more courses of oral corticosteroids per year
 - two or more visits to an emergency department or any hospital admission for asthma

Other priority populations may include:

- those already receiving SABA-only treatment with no concurrent ICS^{3,8}
- patients with worsening symptoms, poor asthma control, increasing reliever use or night waking^{3,9}
- patients following an asthma exacerbation, oral corticosteroid course, urgent care attendance or hospital admission for asthma^{3,9}
- those already receiving ICS-containing therapy who require treatment escalation because asthma remains uncontrolled^{3,9}

Although not an exhaustive list, these groups represent an opportunity to meaningfully improve asthma control and reduce future risk.

In practical terms, the fastest way to identify the highest-priority patients is to run a prescribing search for those coded with asthma who hold only a SABA prescription. This can be done at practice level or through your primary care network, and can be supplemented by opportunistic review during annual asthma appointments, post-exacerbation follow-up and medication review clinics.

Box 1 AIR and MART regimens are linked to fewer severe flare-ups and hospitalisations.^{1,3} For MART specifically, NICE estimates that the benefits per 10,000 patients correspond to:^{1,3}

 **1,133**
fewer GP consultations per year

 **144**
fewer A&E attendances per year

 **80**
fewer hospital admissions per year



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Implementation and management of switching in practice

Once the appropriate treatment – AIR or MART – has been selected based on symptom pattern and patient preference, the consultation should include a clear explanation of the rationale for switching, hands-on inhaler training, and provision of a personalised asthma action plan.³ A follow-up appointment at 4–8 weeks allows early assessment of response, with a full structured review at 8–12 weeks.³

Patients may have a psychological attachment to their blue inhaler, which has offered reassurance for years or even decades.¹ Acknowledging this has the potential to make conversations more productive. An important message for patients is that their new inhaler provides the same rapid symptom relief they are used to (formoterol acts within 1–3 minutes⁶) while simultaneously treating the airway inflammation that causes attacks.² Patients should be assured that by switching they are gaining longer-lasting protection on top of their symptom relief.¹

Consistency of messaging also matters. Patients who encounter conflicting advice from different contacts – particularly in urgent or emergency settings – may revert to SABA.¹ A team-based approach, where all clinical staff reinforce the same rationale, is more likely to support lasting behavioural change.

Concerns about steroid inhalers are common and are frequently amplified by misinformation on social media.¹ Proactively addressing this – explaining that ICS doses in AIR and MART inhalers are low and act locally in the airways – will hopefully reduce hesitancy before becoming a barrier to adherence.

Inhaler choice and technique

Inhaler selection should be guided by the patient's ability to use the device correctly, patient's lifestyle and circumstances, patient preference, and age/competency/physical ability.⁷ Environmental considerations are relevant, but should be secondary to patient suitability and their ability to use specific inhaler types effectively.¹⁰ A pMDI with spacer may be the most appropriate option for patients who struggle with the fast inspiratory effort required for a DPI, those with dexterity or cognitive difficulties, and elderly patients.⁷

Box 2 Inhaler technique checklist – review at every consultation

Only approximately 8% of patients demonstrate good inhaler technique.⁷ Technique should be assessed at every review and whenever a prescription changes⁷

- **pMDI:** slow, steady inhalation (3–5 seconds).¹¹ Hold breath for up to 10 seconds afterwards.¹² Use a spacer to improve effectiveness where required¹¹
- **DPI:** fast, deep inhalation for 2–3 seconds to maximise drug deposition.¹¹ Hold breath for up to 10 seconds afterwards¹²
- **All devices:** exhale fully before use; lift chin slightly; create a tight lip seal; shake before use; wait an appropriate time between puffs (30–60 seconds for pMDI), and rinse mouth after every ICS dose to reduce the chance of side effects.^{11,12}

Cost and formulary considerations

Combination ICS/formoterol inhalers carry a higher unit cost than SABA, but this must be set against significant downstream savings.³ Along with the NICE modelling estimates of reductions in GP visits, A&E attendances and hospital admissions (Box 1), well-controlled asthma is associated with fewer sick days, reduced unplanned contacts and lower long-term healthcare utilisation.¹

Where a branded generic is clinically appropriate and within local formulary, it may offer budget savings without compromising therapeutic equivalence.¹³ Branded generics share the same active ingredients, device type and therapeutic equivalence as their reference product, but are typically available at a lower list price.^{14,15} For example, Luforbec (beclometasone dipropionate/formoterol fumarate, extrafine formulation, pMDI) is a branded generic alternative to Fostair, indicated for the regular treatment of asthma in adults aged ≥18 years where combination ICS/long-acting beta₂ agonist therapy is appropriate;^{5,16} Luforbec 100/6 can be used as MART in appropriate adult asthma patients (>18 years).⁵

Compared to Fostair, Luforbec offers a 52% cost saving at NHS list price (£13.98 vs £29.32 per 120-dose inhaler).^{14,15}

Box 3 Key takeaways from the 2024 (BTS/NICE/SIGN) unified guideline

- SABA monotherapy is not recommended: SABA must not be prescribed in asthma without a concomitant ICS³
- Prioritise review for patients with: non-adherence to medicines; history of SABA overuse (>2 per year), ≥2 corticosteroids per year, and/or ≥2 or more visits to A&E (or any hospital admission for asthma)³
- AIR is first-line for newly diagnosed mild asthma – only certain DPI budesonide/formoterol inhalers are licensed for AIR; no pMDI is currently approved³
- MART is indicated when asthma is not controlled on AIR, or where symptom burden is high from the outset³
- Formoterol acts within 1–3 minutes – reassure patients that switching does not mean losing fast symptom relief⁶
- Inhaler technique should be checked at every review; only ~8% of patients demonstrate good technique⁷
- Combination inhalers reduce exacerbations, A&E attendances and hospitalisations, offsetting higher unit costs^{1,3}
- Branded generics offer equivalent efficacy, with cost savings^{14,15}

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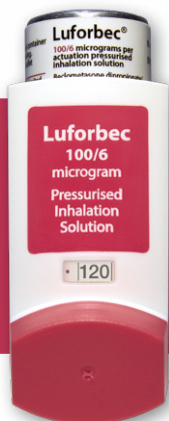
Click or scan the QR code to access the Prescribing and Adverse Event Reporting Information for Luforbec



Move asthma care beyond the blue inhaler with Luforbec 100/6^{1,2}



The 2024 joint BTS/NICE/SIGN asthma guideline marks a shift away from SABA-reliant asthma management, instead recommending ICS/formoterol-based pathways that both relieve symptoms and address underlying airway inflammation.¹



Click or scan the QR code to discover the Luforbec 100/6 MART action plan and patient user guide



The BTS/NICE/SIGN asthma guidelines recommend offering low-dose MART for patients with newly diagnosed asthma presenting highly symptomatic or with a severe exacerbation.¹

A guideline-aligned, cost-saving choice¹⁻³

- Indicated for MART in eligible adult patients with asthma²
- Combines beclometasone/formoterol in one extrafine formulation²
- Delivers therapeutic equivalence to the originator Fostair® (beclometasone/formoterol) in a familiar pMDI device^{2,4,5}
- Offers a 52% saving vs. Fostair, with over £100 million in savings already delivered to the NHS to date (NHS list price)^{3,6}



Adult asthma: Luforbec 100/6 is indicated in the regular treatment of asthma in adults where use of a combination ICS/LABA is appropriate. Luforbec 100/6 can be used as Maintenance and Reliever Therapy (MART) in appropriate adult asthma patients.²

Acronyms: BTS, British Thoracic Society; FEV₁, forced expiratory volume in 1 second; ICS, inhaled corticosteroid; LABA, long-acting beta₂-agonist; MART, Maintenance and Reliever Therapy; NHS, National Health Service; NICE, National Institute for Health and Care Excellence; SABA, short-acting beta agonist; SIGN, Scottish Intercollegiate Guidelines Network.

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