Agent	Brand Name	MOA	Indication	Benefit	Administration	Adverse Effects	Monitoring	Supportive Clinical Documentation	Notes
Anti-IgE									
Omalizumab (SQ)	Xolair	Prevents IgE from binding its receptor on mast cells.	"Atopic-Allergic Asthma" IgE 30-700 IU/mL	Decr exacerbation rate x 25%; decr ICS use.	Injections 0.016 mg/kg per IU of IgE (150-375 mg) q2 or 4 weeks	BBW: Anaphylaxis, rare 1:1000; Epipen Injection site reactions Rare: TIA/CVA, eGPA, fever/arthralgia/rash (warrants d/c)	Body weight	Patient meets eligibility criteria with sensitization on skin prick AND/OR total IgE 30-700 AND/OR frequent exacerbations AND acceptable weight. Patient demonstrates eos >260 uL AND/OR FeNO >20 ppb AND/OR allergen-driven symptoms AND/OR childhood-onset asthma that predicet a good response to Xolair.	Observe 2 hours after initial 3 injections for anaphylaxis/hypersensitivity EXTRA trial and INNOVATE study XPORT study (cont. if favorbale respone in initial 3-6 mo)
Anti-IL5									
Mepolizumab (SQ)	Nucala	Binds to IL-5 ligand --> prevents IL-5 from binding its receptor.	"Eosinophilic Asthma" >150/uL	Decr annual exac rate (upto 60%), improve QoL, decreases CCS use.	100 mg q4 weeks	BBW: Anaphylaxis, rare 1:1000 - Epipen Injection site reactions, headache, angioedema	PFT, exac freq, ACT, SABA: baseline, 3 -6 mo	Patient meets eligibility criteria with eosinophils >*** AND/OR frequent exacerbations. Patient demonstrates eos >*** uL AND/OR frequent exacerbation over last 12 months AND/OR nasal polyps AND/OR adult-onset asthma predicts good response to ***.	Approved for eGPA at higher doses SIRIUS trial
Benralizumab (SQ)	Nucala	Binds IL-5α --> apoptosis of eos and basophils	>300/uL	Above + improved lung function	30 mg q4 wk x 3 then q8 wks	Hypersensitivity reactins: anaphylaxis, angioedema, urticaria	*Common sense*		ZONDA trial
Resilizumab (IV)	Cinqair	Inhibits IL-5 signalling --> decr production, recruitment, activation, survival of eos	>400/uL	Decr exacerbation rate + improved lung function. No studes on decr CCS use.	3 mg/kg q4wks	Increased CPK (transient), myalgia, ororpharyngeal pain Anaphylaxis (3%, as early as 2nd dose)	PFTs, S&S infection, CBC/diff (baseline, periodically)		BREATHE trials
Depemokimab (SQ)	Exdensur	Inhibits IL-5 signalling --> decr production, recruitment, activation, survival of eos	>300/uL (in last 12 mo) -or- >150/uL at screen		100 mcg q6 mo	Hypersensitivity rxns Neutralizing (6%) antibody dvlp (10%), influenza, injection site rxn, arthralgia, allergic rhinitis, pharyngitis URI	PFTs, S&S infection; SABA use (incr use may signal deteriorating asthma)		SWIFT 1 and 2 trials; if dose missed, give ASAP and restart 6 mo from time dose was given
Anti-IL4R									
Dupilumab (SQ)	Dupixent	mAb that targets the IL-4a receptor + IL-4 and IL-13 signalling --> decr IgE production, decr recruitment of inflammatory cells + stimulates goblet cell hyperplasia + modulate airway hyperresponsiveness / remodeling	Peripheral Eos >150/uL -or- Oral CCS dependent -or- FeNO >/= 25 ppb regardless of eos	Decr exac (50-70%), impr lung fxn (rapid), decrease CCS use (x70%, ~50% able to stop completely).	200 or 300 mg q2 weeks	Injection site reactions (</= 18%), and hypereosinophilia (4-14%; transient). Antibody development (1-16%; neutralizing: 1-5%), URI, diarrhea/gastritis, UTI (3%)	CBC/diff baseline, 1 mo, 3mo, periodically (closer if eos >1500)	Patient meets eligibility critera with frequent exacerbations AND/OR eosinophils >150 AND?OR FeNO >25 ppb AND/OR need for maintenance ICS. Patient demonstrates eos >*** AND/OR FeNO >*** AND/OR nasal polyps AND/OR atopic dermatitis that predicts good response to Dupixent.	Also approved for atopic dermatitis. Strong consideration in asthma with chronic rhinosinusitis and/or nasal polyposis. Pos assn w psoriasis/PsArth
Anti-TSLP									
Tezepelumab (SQ)	Tezspire	Blocks thymic stromal lymphopoietin	"Low Type 2 Asthma" Eos <150 -or- Eos 150-1500	Decr annual rate of exacerbations in severe persistent asthma. Improved symptom burden.	210 mcg q4 weeks	Ab development (2-3%; neutralizing <1%), hypersensitivity/anaphylaxis; Influenza; injection site reaction; arthralgia, back pain; epistaxis, pharyngitis	PFTs, S&S infection; SABA use (incr use may signal deteriorating asthma)		NAVIGATOR trials Also approved chronic rhinosinusits w nasal polyposis. Benefit of lower magnitude when eos <300 - still sig decr exac.
Macrolide									
Ch azithro (PO)		Anti-inflammatory	Neutrophil predominant	Decr exac, incr QoL	3x/week (oft MWF)	Diarrhea Hearing loss QT prolongation			BAL cell count/diff or IgE, eos not increased AMAZES trial
Thermoplasty									
Bronchoscopic Tx		Decr asthma w radiogrequence energy	Considered tertiary treatment		Bronch x 3				AIR 2 Trial: decr ED visits, exacerbations, but so did sham

**Curated by Dr. Melanie Garbarino March 2026. Cannot be repilicated or distributed.*

Total daily ICS dose (mcg)				
Inhaled Corticosteroid Doses	**LOW**	**MEDIUM**		**HIGH**
Beclometasone (pMDI, HFA, standard particle)	200-500	>500-1000		>1000
Beclometasone (DPI or pMDI, HFA, extrafine particle)	100-200	>200-400		>400
Budesonide (DPI, pMDI, HFA, standard particle)	200-400	>400-800		>800
Ciclesonide (pMDI, HFA, extrafine particle)	80-160	>160-320		>320
Fluticasone furoate (DPI)	100			200
Fluticasone propionate (DPI)	100-250	>250-500		>500
Fluticasone propionate (pMDI, HFA, standard particle)	100-250	>250-500		>500
Mometasone furoate (DPI)	Depends on DPI device - see product info			
Mometasone furoate (pMDI, HFA, standard particle)	200-400			>400

**Source 2024 GINA guidelines*