Protocol for Management of Allergic and Non-Allergic Rhinitis

The Victorian Community Pharmacist Program

October 2026

VICTORIA State Government | Department of Health

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Contents

1. About 4
1.1. Definitions and acronyms 4
2. Protocol for Management of Allergic and Non-Allergic Rhinitis 5
2.1. Key to colours used in this protocol 5
3. Clinical Documentation Requirements 10
Supplementary information 11
4. Gather information and assess patient's needs 12
4.1. Patient history 12
4.2. Signs and symptoms 13
Table 1 13
4.3. Clinical Review 14
Table 2 15
5. Management and treatment plan 16
5.1. Confirm management is appropriate 18
6. Medicines list 19
7. Communicate agreed management plan 22
7.1. General advice 22
8. Follow up / clinical review 23
9. Resources 24
9.1. Pharmacist resources 24
9.2. Patient resources 25

1. About

This Protocol has been developed to provide pharmacists authorised under the Drugs, Poisons and Controlled Substances Regulations 2017 (the Regulations) a clear framework to supply the Schedule 4 poisons documented in this Protocol for the management of allergic rhinitis and non-allergic rhinitis under a structured prescribing arrangement. It is a requirement of the Secretary Approval: Community Pharmacist Program that pharmacists comply with this Protocol when supplying Schedule 4 poisons for patients seeking treatment for allergic and non-allergic rhinitis. Additional training is not required to provide these treatments, however pharmacists are expected to be competent in the delivery of this service.

Pharmacists authorised to supply Schedule 4 poisons under the Regulations must:

- Operate at all times in accordance with the Drugs, Poisons and Controlled Substances Act 1981, the Regulations and all other applicable Victorian, Commonwealth and national laws.
- At all times act in a manner consistent with the Pharmacy Board of Australia's (the Board) Code of Conduct and in keeping with other professional guidelines and policies as set out by the Board as applicable.

Pharmacists are also expected to exercise professional judgment in adapting treatment guidelines to presenting circumstances.

1.1. Definitions and acronyms

Authorised prescribing health practitioner: A health practitioner authorised under the Drugs, Poisons and Controlled Substances Regulations 2017 to issue a prescription.

AR: Allergic rhinitis

ASCIA: Australasian Society of Clinical Immunology and Allergy

GP: General Practitioner

MHR: My Health Record

Non-AR: Non-allergic rhinitis

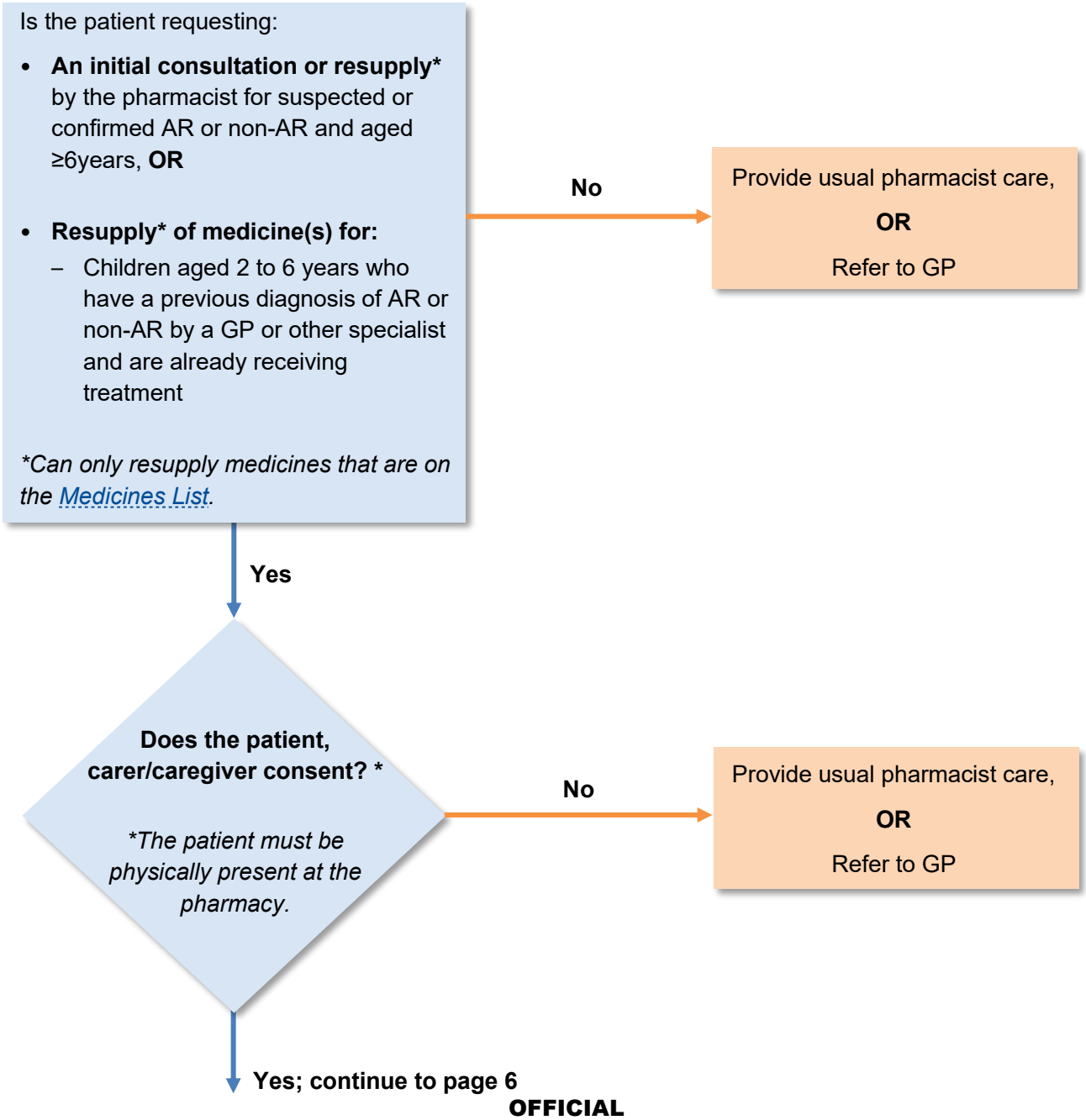
NSAIDs: Nonsteroidal anti-inflammatory drugs

2. Protocol for Management of Allergic and Non-Allergic Rhinitis

2.1. Key to colours used in this protocol

Where the protocol indicates to "Refer to GP," the Pharmacist may refer to a medical practitioner or other authorised prescribing health practitioner as clinically appropriate. If timely access to a GP is not available, referral to the Victorian Virtual Emergency Department (VVED) <https://www.vved.org.au> or an urgent care clinic <https://www.health.vic.gov.au/urgent-care-clinics> may be considered as an alternative pathway. Where appropriate and with patient consent, Aboriginal and Torres Strait Islander patients may also be referred to an Aboriginal Community Controlled Health Organisation (ACCHO).





Continued from page 5

Conduct patient history and clinical review. Considerations include:

Signs and symptoms:

- Onset, nature, duration, frequency, severity and pattern of respiratory symptoms
- Triggering, aggravating and relieving factors (e.g. occupational exposure to cleaning chemicals, foods, pollen, cigarette smoke)
- Emotional, social, and quality of life impacts of the condition
- Assess frequency and severity of symptoms (see 4.3 Clinical review: Table 2)
- Assess for the following, particularly in children:
  - Impact on sleep quality
  - Behavioural, cognitive or concentration difficulties

Differential diagnoses & medical history:

- Signs or symptoms of systemic illness or infection
- Presence of asthma symptoms, including potential new asthma presentation or acute asthma exacerbation
- History of asthma and current asthma management plan
- Prescence of sinusitis symptoms
- Co-existing and underlying medical conditions, including nasal structural abnormalities, or recent nasal surgery or trauma
- History of other atopic conditions (e.g. eczema)

Medication history:

- Response to any medication(s) used to treat symptoms, including intranasal decongestants
- Current medications, medication allergies or adverse reactions
- Previous AR or non-AR treatments trialled and whether they were effective or not

Continue to page 7

Continued from page 6

Does the patient have any acute respiratory signs, red flags, or exclusions?

- Unable to make clear diagnosis of AR or non-AR
- Children <6 years of age without a prior diagnosis of AR or non-AR
- Significant sleep disturbances or behavioural and cognitive impacts (e.g. impaired concentration, learning difficulties or reduced school performance), particularly in children.
- Signs or symptoms of systemic illness or respiratory infection, e.g. fever, cough, shortness of breath and patient generally unwell
- Potential new presentation of asthma
- Acute exacerbation of asthma
- Uncontrolled asthma in a patient under age 16
- Symptoms of sinusitis infection, e.g. facial pain, mucopurulent nasal discharge, or loss of sense of smell
- Oral symptoms suggestive of oral-food allergy syndrome (or pollen-food allergy syndrome)
- Unilateral ocular symptoms (e.g. redness, discharge)
- Any changes in vision, eye pain or changes in colour vision
- Underlying or co-existing medical conditions that complicate treatment for rhinitis, e.g. nasal polyps, other nasal structural abnormalities, recurrent epistaxis, recent nasal surgery or trauma
- Rhinitis suspected to be caused or exacerbated by a medicine prescribed by another health practitioner (e.g. rhinitis medicamentosa due to intranasal decongestants)
- The condition has not responded to optimal treatment after 4 weeks or worsens

Yes → **Refer to GP**

No

Does the patient have signs/symptoms that warrant treatment AND referral?

- The condition is having a significant negative emotional, social, or quality of life impacts on the patient
- Patients with uncontrolled asthma*

**Needs GP referral for review of asthma plan and overall management*

Yes → Establish management plan for AR or non-AR **AND** Refer to GP

No; continue to page 8

Continued from page 7

Establish management plan for AR or non-AR, including review of patient's age, contraindications, precautions, frequency and severity of symptoms (see 4.3 Clinical review: Table 2)

- Refer to Medicines List for treatments available under this protocol.

Allergic Rhinitis:

Where possible, identify allergens or irritants and avoid or minimise exposure.

Standard treatment:

- Mild symptoms:
  - Oral OR intranasal **antihistamine**
- Moderate to severe symptoms:

First line:

  - Oral OR intranasal **antihistamine**
  - PLUS, **intranasal corticosteroid**

First line alternative:

  - **Combination intranasal** antihistamine + corticosteroid

Management of persistent symptoms (not responding to appropriate standard treatment):

- Persistent nasal congestion:
  - **Intranasal antihistamine** OR
  - **Combination intranasal** antihistamine + corticosteroid
- Persistent allergic conjunctivitis:
  - ADD **eye drop with antihistamine and/or mast cell stabilising properties**

Non-Allergic Rhinitis:

Where possible, minimise exposure to known irritants.

Standard treatment:

- **Intranasal corticosteroid**

Note: intranasal antihistamine or oral antihistamine are not indicated for non-AR.

Confirm management plan is appropriate with regards to contraindications, precautions, interactions, pregnancy and lactation status (if applicable)

Continue to page 9

Continued from page 8

Provide non-pharmacological and self-care advice

Provide advice on non-pharmacological, general and preventative measures:

- Identify and minimise exposure to confirmed allergens where possible
- Where relevant, implement allergen avoidance measures, such as reducing exposure to pollen, house dust mites, animal dander, moulds or other identified allergens.
- During periods of high pollen exposure, consider keeping windows closed, using air conditioning where available, and showering and changing clothes after spending time outdoors.
- Provide counselling on correct nasal spray and eye drop technique where applicable

Communicate agreed treatment plan to patient and other healthcare professionals:

- Dispense medications via pharmacy dispensing software
- Provide counselling of selected treatment (e.g. dose, duration, application advice) including adverse effects and how to manage them
- Duration of treatment and expectations around resolution of symptoms
- Advise when to seek further care e.g. If signs and symptoms do not improve after 4 weeks of optimal treatment with an intranasal corticosteroid
- Provide written patient information where appropriate, e.g. **ASCIA Treatment Plan for Allergic Rhinitis (Hayfever)** and the patient handout <https://www.allergy.org.au/patients/allergic-rhinitis-hay-fever-and-sinusitis/allergic-rhinitis-treatment-plan>

Document the consultation and provide a record of the service to the patient and, where applicable, the patient's usual GP or medical practice where the patient has one.

3. Clinical Documentation Requirements

The pharmacist must make a clinical record of the consultation that contains:

- Sufficient information to identify the patient (Medicare number and date of birth are usually recorded when dispensing prescriptions)
- Date of treatment
- Name of the pharmacist who undertook the consultation and their Healthcare Provider Identifier-Individual (HPI-I) number
- Consent given by the patient regarding: Program participation, costs, pharmacist communication with other healthcare practitioners (e.g. patient's usual treating GP) and access to the patient's My Health Record for the purpose of checking inclusion/exclusion criteria and uploading information relating to the consultation as required
- Any information known to the pharmacist that is relevant to the patient's diagnosis or treatment and any observations and assessments including allergies and adverse reactions
- Any clinical opinion reached by the pharmacist
- Actions taken by the pharmacist (including any medications supplied or referrals made to a medical practitioner)
- Particulars of any medications supplied to the patient (such as form, strength and amount)
- Information or advice given to the patient in relation to any treatment proposed by the pharmacist who is treating the patient

Document the consultation and provide a record of the service to the patient and, where applicable, the patient's usual GP or medical practice if a Schedule 4 medicine is supplied.

The pharmacist must make a record in the pharmacy software, and an IT system approved by the Victorian Department of Health, regarding the supply. This record must be made available to the Department on request.

Supplementary information

The supplementary information below provides additional guidance and information to Victorian pharmacists participating in the Community Pharmacist Program (the Program). It is intended to be used together with the guidelines and other resources referred to here to assist pharmacists in adhering to the management protocol and facilitate delivery of a safe and high-quality to the community for the management of allergic and non-allergic rhinitis.

4. Gather information and assess patient's needs

Rhinitis is an inflammation of the mucosal lining of the nose and may be classified as allergic, non-allergic, infectious, occupational (caused by workplace irritants), or drug-induced (causes include aspirin, NSAIDs, vasodilators, rebound symptoms from intranasal decongestants, and estrogen-containing preparations).

Allergic rhinitis

Allergic rhinitis is the most common form of rhinitis, affecting around 24% of the Australian population in 2022. It is associated with an immunoglobulin E (IgE)-mediated immune response to environmental allergens, which can be seasonal (e.g. pollens) or perennial (e.g. dust mites, cat and dog dander). Symptoms can be aggravated by chemical irritants (e.g. smoke). Allergic rhinitis commonly coexists with asthma, sinusitis, and atopic dermatitis.

Non-allergic rhinitis

Rhinitis presenting without an identifiable allergic trigger or infective cause is referred to as non-allergic rhinitis. Allergy testing is not necessary to confirm a diagnosis of nonallergic rhinitis. Diagnosis is based on physical examination, patient history and the presence of symptoms in the absence of allergens.

4.1. Patient history

Sufficient information must be obtained from the patient to assess the safety and appropriateness of any recommendations and medicines for the patient.

Considerations include:

- Age
- Pregnancy and lactation status (if applicable)
- Onset, nature, duration, frequency, severity and pattern of respiratory symptoms
- Triggering, aggravating and relieving factors (e.g. occupational exposure to cleaning chemicals, foods, pollen, cigarette smoke)
- Emotional, social, and quality of life impacts of the condition
- Personal and family history of allergic disease (e.g. atopic dermatitis, asthma, or rhinitis)
- Signs or symptoms of systemic illness or infection (e.g. fever, patient generally unwell)
- Signs or symptoms of asthma (e.g. wheezing)
- Signs or symptoms of sinusitis (e.g. facial pain, mucopurulent nasal discharge, or loss of sense of smell)
- Underlying or co-existing medical conditions that complicate treatment for rhinitis (e.g. nasal polyps, other nasal structural abnormalities, recurrent epistaxis, recent nasal surgery or trauma)
- Smoking and vaping status
- Current medications (including prescribed medicines, vitamins, herbs, other supplements and over-the-counter medications)
- Medication used or trialled to treat symptoms, adherence and response, including use of intranasal decongestants
- Medication allergies or adverse reactions

The patient's My Health Record can be used, to access a range of clinical information including details about current and past medication history, allergies and current medical conditions.

Working with Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander cultures may experience barriers towards seeking health care.

Access to care may be influenced by factors such as privacy concerns, community visibility and experiences of racism. Pharmacists should ensure consultations occur in a private, comfortable and culturally safe space, take a holistic and person-centred approach, and allow adequate time for discussion.

To build knowledge around understanding culture, building relationships and communication, pharmacists should consult the Victoria's Department of Health Aboriginal and Torres Strait Islander Cultural Safety Framework <https://www.health.vic.gov.au/publications/aboriginal-and-torres-strait-islander-cultural-safety-framework-part-1> and the Pharmaceutical Society of Australia's Guideline for Pharmacists supporting Aboriginal and Torres Strait Islander peoples with Medicines Management <https://my.psa.org.au/s/article/Providin-Pharmacy-Services-to-Aboriginal-and-Torres-Strait-Islander-People>.

Where appropriate and with consent, Aboriginal and Torres Strait Islander patients should be referred to an Aboriginal Community Controlled Health Organisation (ACCHO). A list of Victorian Aboriginal Community Controlled Health Organisation (VACCHO) member Aboriginal Community-Controlled Organisations (ACCOs) is available at: https://www.vaccho.org.au/members/.

4.2. Signs and symptoms

Table 1

Allergic Rhinitis	Non-allergic Rhinitis
Symptoms occur after exposure to pollen, dust, animals, or other environmental allergens: • Sneezing • Nasal congestion • Clear rhinorrhea • Upper airway cough syndrome (post-nasal drip) • Mucosal itching of the nose, ears, and palate • Allergic conjunctivitis (eye redness, watering, and itching) commonly co-exists Non-specific symptoms: • 'Fuzzy' head • Tiredness and daytime sleepiness • Constant 'colds' In children, additional symptoms may include: • Sniffing • Blinking and eye rubbing • Voice quality • Snoring or mouth breathing • Dark undereye circles. Reported symptom improvement after use of less-sedating antihistamines and/or intranasal corticosteroids is strongly suggestive of allergic rhinitis.	Symptoms without an identifiable infectious or allergic cause: • Nasal blockage and/or congestion • Clear rhinorrhoea • Post-nasal drip May or may not be present: • Sneezing • Itchy nose, ears or throat. Symptoms may present sporadically at any time of the year, although they may be exacerbated by environmental factors such as barometric pressure or temperature changes, bright lights or physical irritants.

Red flag signs or patient ineligibility criteria

Pharmacists must refer patients to a medical practitioner immediately if:

- Unable to make clear diagnosis of AR or non-AR
- Children <6 years of age without a prior diagnosis of AR
- Significant sleep disturbances or behavioural and cognitive impacts (e.g. impaired concentration, learning difficulties or reduced school performance), particularly in children.
- Signs or symptoms of systemic illness or respiratory infection, e.g. fever, cough, shortness of breath and patient generally unwell
- Potential new presentation of asthma
- Acute exacerbation of asthma
- Uncontrolled asthma in a patient under age 16
- Signs or symptoms of sinusitis, e.g. facial pain, mucopurulent nasal discharge, or loss of sense of smell
- Oral symptoms suggestive of oral food allergy syndrome (or pollen-food allergy syndrome)
- Unilateral ocular symptoms (e.g. redness, discharge)
- Any changes in vision, eye pain or changes in colour vision
- Underlying or co-existing medical conditions that complicate treatment for rhinitis, e.g. nasal polyps, other nasal structural abnormalities, recurrent epistaxis, recent nasal surgery or trauma
- Rhinitis suspected to be caused or exacerbated by a medicine prescribed by another health practitioner (e.g. rhinitis medicamentosa due to intranasal decongestants)
- The condition has not responded to optimal treatment after 4 weeks or worsens

Pharmacists may provide initial treatment and concurrently refer to medical practitioner if:

- The condition is having a marked negative emotional, social or quality of life impacts on the patient
- Patients with uncontrolled asthma

4.3. Clinical Review

Physical examination of nose, throat, eyes and ears is generally required. Where appropriate, conduct an assessment of vital signs.

Outward signs of allergic rhinitis may include:

- Rubbing at the nose or an obvious transverse nasal crease
- Swollen, pale, boggy nasal mucosa, with thin secretions
- Mouth breathing
- Sniffling or throat clearing
- Cobblestone throat
- Allergic shiners (dark circles under the eyes due to nasal congestion), particularly in children
- Allergic conjunctivitis (eye redness, watering)

Assess patients presenting with allergic rhinitis for co-existing sinusitis or asthma.

Refer to appropriate resources such as ‘ASCIA Allergic Rhinitis Clinical Update’ for more information <https://www.allergy.org.au/hp/papers/allergic-rhinitis-clinical-update>.

Based on the clinical review and assessment findings, use **Table 2** below to determine the severity of the patient's AR or non-AR and to assist in guiding treatment selection.

Table 2

Frequency and duration of symptoms	
Intermittent symptoms	**Persistent symptoms**
on fewer than 4 days a week OR for fewer than 4 consecutive weeks	on more than 4 days a week OR for more that 4 consecutive weeks
Severity of symptoms	
Mild	**Moderate to severe**
all the following: • symptoms present but not troublesome • no sleep disturbance • no impairment of daily activities, leisure or sport no impairment of school or work performance	one or more of the following: • troublesome symptoms • sleep disturbance • impairment of daily activities, leisure or sport impairment of school or work performance

5. Management and treatment plan

ALLERGIC RHINITIS

General management:

- Where possible, identify allergens or irritants, and avoid or minimise exposure.
- Sodium chloride 0.9% nasal irrigation may help to clear nasal passages by washing out allergens and mucus and reducing congestion and irritation.
- Sodium chloride 0.9% eye drops or eye washes may help with allergic conjunctivitis.
- Patients with allergic rhinitis are at increased risk of thunderstorm asthma.
- Useful patient information is available from: ASCIA Treatment Plan for Allergic Rhinitis (Hayfever) <https://www.allergy.org.au/patients/allergic-rhinitis-hay-fever-and-sinusitis/allergic-rhinitis-treatment-plan>

Medication management:

Standard treatment:

Mild symptoms:

- Oral OR intranasal **antihistamine**

Note: Combining oral and intranasal antihistamine therapy does not confer additional benefit.

Moderate to severe symptoms:

- Oral OR intranasal **antihistamine**
- PLUS, intranasal **corticosteroid**

- First line alternative: **Combination intranasal antihistamine + corticosteroid**

Management of persistent symptoms (not responding to appropriate standard treatment):

Persistent nasal congestion:

- **Intranasal antihistamine** OR
- **Combination intranasal antihistamine + corticosteroid** formulation

Persistent allergic conjunctivitis:

- ADD **eye drop with antihistamine and/or mast cell stabilising properties**

NON-ALLERGIC RHINITIS

General management:

- In patients with nonallergic rhinitis caused by a clinically obvious irritant, minimise exposure to the irritant if possible.
- Topical antihistamines and oral antihistamines are not indicated for non-AR.
- Intranasal corticosteroids are the mainstay of treatment. Dosages are the same as those used for AR

Medication management:

Intranasal corticosteroid

- Use a high dose therapy for 2 to 4 weeks and then reduce to a maintenance dose

Refer to **MEDICINES LIST** for treatments available under this protocol.

Notes on treatment options:

Antihistamines:

- Oral less-sedating antihistamines appear to be equally effective, but response can vary between patients. Consider trialling an alternative oral antihistamine if response is inadequate, or for persistent nasal obstruction, consider switching to an intranasal antihistamine.
- If you are using two different nasal sprays, wait 10 minutes between sprays.
- Intranasal antihistamines have no effect on extra-nasal symptoms. Choice of intranasal antihistamine depends on individual response and tolerability. Azelastine and olopatadine also have mast cell stabilising properties.
- If allergic rhinitis symptoms are adequately managed with an oral or intranasal antihistamine alone after trialling a new treatment for 4 weeks, review with a pharmacist will generally not be required and the patient may be advised to remain on the minimum effective dose.
- Patients with intermittent symptoms that occur seasonally may only require antihistamines for a few months of the year, while others may require long-term treatment.
- If symptoms are not resolved after optimal use of antihistamine, consider addition of intranasal corticosteroid.

Intranasal corticosteroids:

- Instruct patients on correct intranasal spray technique. Using a crossover technique (right hand to left nostril, or left hand to right nostril) reduces deposition of the corticosteroid directly onto the nasal septum and reduces the likelihood of causing nasal septal perforation.
- Review is recommended 4 weeks after initiation to assess for response to treatment, intranasal spray technique and adverse effects.
- To reduce the likelihood of systemic adverse effects, reduce to maintenance dosing after 4 weeks of initial therapy and tailor the duration of treatment to the patient's symptoms. Patients with intermittent symptoms that occur seasonally may only require treatment for a few months of the year, while others may require long-term treatment.

Intranasal antihistamine + corticosteroid:

- A fixed dose combination intranasal spray may be used if nasal congestion is not adequately controlled with either antihistamine or corticosteroid alone.
- If the patient is already taking an oral antihistamine, it should be stopped before starting the combination intranasal spray.

Eye drops with antihistamine and/or mast cell stabilising properties:

- May be used for allergic conjunctivitis symptoms not responding to an oral/intranasal antihistamine or intranasal corticosteroid.
- **Antihistamine** eye drops (e.g. levocabastine) provide rapid relief of symptoms.
- **Mast cell stabiliser** eye drops (e.g. cromoglycate, lodoxamide) have a delayed onset (around 2 weeks) but provide longer-term relief of symptoms.
- Eye drops with **both antihistamine and mast cell stabilising properties** (e.g. azelastine, ketotifen, olopatadine) provide both short- and long-term relief of symptoms and appear to be more effective than drugs with only antihistamine or mast cell stabilising properties.
- If ocular symptoms do not respond after 4 weeks, refer to an optometrist, ophthalmologist, or other specialist for review.

Intranasal saline therapy for AR:

- Intranasal saline therapy for allergic rhinitis aims to clear the nose of mucus, facilitate application of other nasal sprays and reduce aeroallergens around the sinus drainage pathways.
- Frequent application of nasal irrigations with larger volumes of saline (e.g. 60 mL or more of sodium chloride 0.9%) is more effective than sprays (e.g. 1 mL or less of sodium chloride 0.9%), although children may not tolerate irrigation with larger volumes. The technique of irrigations is learned, and adults should be encouraged to persist. If forceful irrigation is painful, suggest a small volume wash with a gradual gentle technique.
- Patient information on how to use Fess (an example brand of nasal saline rinse) is available from the National Asthma Council website < https://www.nationalasthma.org.au/living-with-asthma/how-to-videos/how-to-perform-nasal-irrigation-with-fess-nasal-sinus-wash>.

5.1. Confirm management is appropriate

Pharmacists must have access to the Therapeutic Guidelines, Australian Medicines Handbook, and other relevant references to confirm the management is appropriate, including for:

- Contraindications and precautions
- Medicine interactions
- Pregnancy and lactation

6. Medicines list

The Program authorises the supply of certain intranasal corticosteroids, antihistamines, and antihistamine and/or mast cell stabilising eye drops for the treatment of AR and non-AR where these are indicated. These include:

- **Ciclesonide (intranasal formulation)**
- **Fluticasone furoate (intranasal formulation)**
- **Olopatadine 0.1% (eye drops)**

Note: There are no changes to the scope for pharmacists to supply Schedule 2 and 3 treatments for AR and non-AR.

Intranasal corticosteroids

Intranasal corticosteroid	Dose per spray	Initial dose (for 4 weeks) (into each nostril)	Maintenance dose [NB1] (into each nostril)	Brand name examples
beclometasone	50 micrograms	**adult:** 2 sprays, twice daily **child 6 years and older:** 1 to 2 sprays twice daily	1 spray twice daily	Beconase Allergy & Hayfever 12 Hour
budesonide	32 micrograms	**adult or child 6 years and older:** 2 sprays twice daily, or 4 sprays once daily	1 to 2 sprays once daily	Rhinocort Hayfever: 32 microg /spray
	64 micrograms	**adult or child 6 years and older:** 1 spray twice daily, or 2 sprays once daily	1 spray once daily	Budamax, Rhinocort: 64 microg /dose
ciclesonide	50 micrograms	**adult or child 6 years and older:** 2 sprays once daily	2 sprays once daily [NB2]	Omnaris*
fluticasone furoate	27.5 micrograms	**adult:** 2 sprays once daily **child 2 to 11 years:** 1 to 2 sprays once daily	1 spray once daily	Avamys
fluticasone propionate	50 micrograms	**adult or child 12 years and older:** 2 sprays once daily	1 spray once daily	Flixonase Allergy & Hayfever 24 Hour
mometasone	50 micrograms	**adult:** 2 sprays once daily **child 3 to 11 years:** 1 spray once daily	1 spray once daily	Nasonex, Azonaire, Sensease

*Omnaris: should only been used for up to 12 weeks in children aged between 6 and 12 years

NB1: Maintenance dose is the same for adults and children.

NB2: Based on lack of available clinical data, the manufacturer does not recommend decreasing the initial dose of ciclesonide.

Oral antihistamines (less-sedating)

Oral antihistamine	Adult dose	Child dose
cetirizine	10 mg orally, daily	**child 1 to 2 years:** 0.25 mg/kg (up to 2.5 mg) twice daily **child 2 to 5 years:** 5 mg daily as a single dose or in divided doses **child 6 years or older:** 10 mg daily as a single dose or in divided doses
desloratadine	5 mg orally, daily	**child 1 to 5 years:** 1.25 mg once daily **child 6 to 11 years:** 2.5 mg once daily **child 12 years or older:** 5 mg once daily
fexofenadine	120 to 180 mg orally, daily as a single dose or in divided doses	**child 2 to 11 years:** 30 mg twice daily **child 12 years or older:** 120 to 180 mg daily as a single dose or in divided doses
loratadine	10 mg orally, daily	**child 1 to 2 years:** 2.5 mg once daily **child 2 years or older, weight 30 kg or less:** 5 mg once daily **child 2 years or older, weight more than 30 kg:** 10 mg once daily
bilastine	20mg orally, daily	**child 12 years or older:** 20mg once daily

Intranasal antihistamines

Intranasal antihistamine	Strength	Dose	Brand name examples
azelastine	1 mg/mL	**adult or child 5 years or older:** 1 spray into each nostril, twice daily	Azep
levocabastine	0.5 mg/mL	**adult or child 6 years or older:** 2 sprays into each nostril, 2 to 4 times daily	Livostin, Zyrtec Levocabastine

Intranasal antihistamine + corticosteroid combinations

Intranasal antihistamine with intranasal corticosteroid	Strength	Dose	Brand name examples
azelastine + fluticasone	azelastine 125 microg + fluticasone proprionate 50 microg /dose	**adult or child 6 years or older:** 1 spray into each nostril, twice daily	Dymista* 125/50
olopatadine + mometasone	olopatadine 600 microg + mometasone 25 microg /dose	**adult or child 12 years or older:** 2 sprays into each nostril, twice daily **child 6 to 11 years:** 1 spray into each nostril, twice daily	Ryaltris#

*In children 6 to 11 years of age, safety of Dymista 125/50 beyond 3 months of use has not been assessed.

#In children 6 to 11 years of age, safety of Ryaltris® beyond 2 weeks of use has not been assessed.

Eye drops for allergic conjunctivitis

Medication (eye drop)	Strength	Dose	Brand name examples
Antihistamine & mast cell stabilising:			
azelastine	0.05%	**adult or child 4 years or older:** 1 drop into both eyes, 2 to 4 times daily	Eyezep
ketotifen	0.025%	**adult or child 3 years or older:** 1 drop into both eyes, twice daily	Zaditen
olopatadine	0.1%	**adult or child 3 years or older:** 1 drop into both eyes, twice daily	Patanol*
Antihistamine:			
levocabastine	0.05%	**adult or child 6 years or older:** 1 drop into both eyes, 2 to 4 times daily	Livostin, Zyrtec Levocabastine
Mast cell stabiliser:			
cromoglycate	2%	**adult or child:** 1 drop into both eyes, 4 to 6 times daily	Cromo-Fresh
lodoxamide	0.1%	**adult or child 4 years or older:** 1 drop into both eyes, 4 times daily	Lomide

*Olopatadine should only be used for a maximum duration of 14 weeks.

7. Communicate agreed management plan

Comprehensive advice and counselling (including written information when required) as per the Therapeutic Guidelines, Australian Medicines Handbook, and other relevant references, should be provided to the patient regarding:

- Individual product and medicine use, e.g. dosing and correct intranasal spray technique
- How to manage potential adverse effects
- When to seek further care and/or treatment
- Patients with allergic rhinitis are at increased risk of thunderstorm asthma.
- Useful patient information is available from: **ASCIA Treatment Plan for Allergic Rhinitis (Hayfever)** <https://www.allergy.org.au/patients/allergic-rhinitis-hay-fever-and-sinusitis/allergic-rhinitis-treatment-plan>

It is the pharmacist's responsibility to ensure the suitability and accuracy of any resources provided to patients (and parents/carers if applicable), and to ensure these comply with all copyright conditions.

The agreed management plan should be shared with members of the patient's multidisciplinary healthcare team, with the patient's consent and where appropriate.

7.1. General advice

General advice should be provided to the patient regarding strategies to support management of AR or non-AR:

- Avoid or minimise exposure to known triggers where possible.
- Where relevant, implement allergen avoidance measures, such as reducing exposure to pollen, house dust mites, animal dander, moulds or other identified allergens.
- Saline nasal irrigation or saline nasal sprays may help relieve nasal congestion, clear irritants and improve nasal symptoms.
- Oral and nasal decongestants have no role in AR or non-AR treatment and should be avoided
- Avoid exposure to tobacco smoke, vaping products and other airborne irritants that may worsen symptoms.
- Maintain adequate hydration.
- During periods of high pollen exposure, consider keeping windows closed, using air conditioning where available, and showering and changing clothes after spending time outdoors.
- Patients using intranasal medicines or antihistamine / mast cell eye drops should be counselled on correct administration technique to maximise treatment effectiveness and minimise adverse effects.

8. Follow up / clinical review

Patients commenced on an intranasal corticosteroid should be advised that some improvement in symptoms is typically expected within 1 to 2 weeks, however maximum benefit may take up to 4 weeks. Treatment should generally be continued for at least 4 weeks before response is assessed.

Patients commenced on an oral non-sedating antihistamine should be advised that symptom relief is usually expected within hours to a few days of treatment initiation. If symptoms remain inadequately controlled despite appropriate use, treatment should be reviewed and consideration given to alternative or additional therapy.

Patients whose ocular symptoms do not improve after 1 week of treatment with antihistamine and/or mast cell stabilising eye drops should be considered for referral to an optometrist or other appropriate specialist for further evaluation.

At follow-up, assess symptom control and adherence to therapy and, where relevant, confirm correct administration technique for intranasal sprays and eye drops before considering treatment escalation.

Patients who do not respond to optimised treatment should be referred to a medical practitioner for review of alternative diagnoses or consideration of onward referral to an allergy specialist for assessment of suitability for allergen immunotherapy.

Patients with rhinitis symptoms that persist for more than 3 months, including those whose symptoms are well controlled with treatment, should be referred to a medical practitioner for further assessment and ongoing management of a chronic condition.

9. Resources

9.1. Pharmacist resources

Therapeutic Guidelines: Allergic and Non-allergic rhinitis

- Therapeutic Guidelines
  <https://www.tg.org.au>

Australian Medicines Handbook: Rhinitis

- Australian Medicines Handbook
  <https://amhonline.amh.net.au/auth>

Australasian Society of Clinical Immunology and Allergy:

- Allergic Rhinitis Clinical Update
  <https://www.allergy.org.au/hp/papers/allergic-rhinitis-clinical-update>

Australian Family Physician (RACGP):

- Allergic rhinitis: Practical management strategies
  <https://www.racgp.org.au/afp/backissues/2008/23538>

The Royal Children's Hospital Melbourne:

- Allergic rhinitis hay fever
  <https://www.rch.org.au/primary-care-liaison/prereferral_guidelines/Allergic_rhinitis_hay_fever/>

Australian Government, Department of Health, Disability and Ageing: Pregnancy, birth & baby:

- Hay fever during pregnancy
  <https://www.pregnancybirthbaby.org.au/pregnancy/health-conditions-and-complications/hay-fever-during-pregnancy>

A list of Victorian Aboriginal Community Controlled Health Organisations (ACCHOs) is available at:

- Members - VACCHO
  <https://www.vaccho.org.au/members/>

9.2. Patient resources

Australasian Society of Clinical Immunology and Allergy:

- Treatment Plan for Allergic Rhinitis (Hayfever)
  <https://www.allergy.org.au/patients/allergic-rhinitis-hay-fever-and-sinusitis/allergic-rhinitis-treatment-plan>

Therapeutic Guidelines: Allergic Rhinitis:

- Instructions for using a nasal spray
  <https://ccmsfiles.tg.org.au/s2/PDFs/RSG6_PDF_Box9.3_NasalSprayInstructions_v1.pdf>

National Asthma Council Australia:

- Videos: Using your nasal spray and irrigation
  <https://www.nationalasthma.org.au/living-with-asthma/how-to-videos>

Allergy & Anaphylaxis Australia:

- Allergic rhinitis (hay fever)
  <https://allergyfacts.org.au/__interest/allergic-rhinitis/>

Better Health Channel:

- Hay fever
  <https://www.betterhealth.vic.gov.au/health/conditionsandtreatments/hay-fever>

The Royal Children's Hospital Melbourne:

- Hay fever
  <https://www.rch.org.au/kidsinfo/fact_sheets/hay_fever/>

National Asthma Council Australia:

- Thunderstorm asthma
  <https://www.nationalasthma.org.au/living-with-asthma/resources/patients-carers/factsheets/thunderstorm-asthma>

Australasian Society of Clinical Immunology and Allergy:

- ASCIA Non-allergic Rhinitis FAQ
  <https://www.allergy.org.au/patients/allergic-rhinitis-hay-fever-and-sinusitis/non-allergic-rhinitis>

myDr Australia:

- Non-allergic rhinitis
  <https://mydr.com.au/symptoms/nonallergic-rhinitis-causes-and-treatment/>