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Prescribing is Also Caring: Medication Prescribing in Primary Health Care Nursing Protocols

Prescrever Também é Cuidar: Prescrição Medicamentosa em Protocolos de Enfermagem da Atenção Primária à Saúde

Prescribir También es Cuidar: Prescripción de Medicamentos en Protocolos de Enfermería de Atención Primaria de Salud

Abstract

Objective: To investigate the prescriptive content of the Primary Health Care Nursing Protocols of the São Paulo Municipal Health Department and to develop a reference matrix for medications that nurses are authorized to prescribe. **Method:** This is a qualitative study. The document corpus comprised four municipal nursing protocols on child and adolescent health, adult health, elderly health, and women's health. Through a targeted search and comprehensive reading of the prescriptive sections, we extracted the active ingredient, indication, target population, prescribing modality, and prescribing conditions. The data were subjected to descriptive and categorical analysis. **Results:** A total of 49 active ingredients or combinations were identified, distributed across 12 therapeutic groups. Anti-infectives, cardiovascular medications, and drugs for prevalent conditions predominated. The protocols distinguished between the initiation of therapy, continuity of medical treatment, and prescriptions contingent on specific programs or routines. Links to the Nursing Process, institutional protocols, clinical records, and monitoring were recurrent. **Conclusion:** The corpus documents a broad prescribing scope, though one that is contingent upon clinical assessment, professional competence, and institutional governance. Consolidating the recommendations into a medication matrix can support continuing education, electronic systems, and medication safety audits.

Descriptors: Drug Prescriptions; Nursing; Primary Health Care; Clinical Protocols; Patient Safety.

Resumo

Objetivo: Investigar o conteúdo prescritivo dos Protocolos de Enfermagem da Atenção Primária à Saúde da Secretaria Municipal da Saúde de São Paulo e, construir uma matriz de consulta aos medicamentos com prescrição atribuída a enfermeiros. **Método:** Trata-se de estudo qualitativo. O corpus documental reuniu quatro protocolos de enfermagem municipais sobre saúde da criança e ao adolescente, da pessoa adulta, da pessoa idosa e da saúde da mulher. Mediante busca dirigida e leitura integral das seções prescritivas, extraíram-se princípio ativo, indicação, população, modalidade prescritiva e condicionantes. Os dados foram submetidos à análise descritiva e categorial. **Resultados:** Foram identificados 49 princípios ativos ou associações, distribuídos em 12 grupos terapêuticos. Predominaram anti-infecciosos, medicamentos cardiovasculares e fármacos para condições prevalentes. Os protocolos diferenciaram início terapêutico, continuidade de tratamento médico e prescrição condicionada a programas ou rotinas. A vinculação ao Processo de Enfermagem, aos protocolos institucionais, ao registro clínico e ao monitoramento foi recorrente. **Conclusão:** O corpus documenta escopo prescritivo amplo, porém condicionado à avaliação clínica, à competência profissional e à governança institucional. A consolidação das recomendações em uma matriz de medicamentos pode apoiar educação permanente, sistemas eletrônicos e auditoria da segurança medicamentosa.

Descritores: Prescrições de Medicamentos; Enfermagem; Atenção Primária à Saúde; Protocolos Clínicos; Segurança do Paciente.

Resumen

Objetivos: Investigar el contenido prescritivo de los Protocolos de Enfermería de la Atención Primaria de Salud de la Secretaría Municipal de Salud de São Paulo y elaborar una matriz de consulta sobre los medicamentos cuya prescripción se atribuye a los enfermeros. **Método:** Se trata de un estudio cualitativo. El corpus documental reunió cuatro protocolos municipales de enfermería sobre salud infantil y adolescente, de adultos, de personas mayores y de salud de la mujer. Mediante una búsqueda dirigida y la lectura integral de las secciones prescritivas, se extrajeron el principio activo, la indicación, la población, la modalidad de prescripción y los condicionantes. Los datos se sometieron a un análisis descriptivo y categorial. **Resultados:** Se identificaron 49 principios activos o combinaciones, distribuidos en 12 grupos terapéuticos. Predominaron los antiinfecciosos, los medicamentos cardiovasculares y los fármacos para afecciones prevalentes. Los protocolos diferenciaron entre inicio terapéutico, continuidad del tratamiento médico y prescripción condicionada a programas o rutinas. La vinculación con el proceso de enfermería, los protocolos institucionales, el registro clínico y el seguimiento fue recurrente. **Conclusión:** El corpus documenta un amplio alcance prescriptivo, aunque condicionado a la evaluación clínica, la competencia profesional y la gobernanza institucional. La consolidación de las recomendaciones en una matriz de medicamentos puede apoyar la educación continua, los sistemas electrónicos y la auditoría de la seguridad de los medicamentos.

Descriptores: Prescripciones de Medicamentos; Enfermería; Atención Primaria de Salud; Protocolos Clínicos; Seguridad del Paciente.

INTRODUCTION

Medication prescribing by nurses is an integral part of care organization in various health systems. Its scope varies according to legislation, training, protocols, and clinical governance mechanisms. International reviews describe a gradual expansion of prescribing autonomy, especially in primary care, in the management of chronic conditions, and in public health programs. This practice can reduce barriers to access and enhance continuity of care, provided there is clinical competence, institutional support, and evaluation of therapeutic outcomes^(1,2).

In Brazil, Law No. 7,498/1986 authorizes nurses to "prescribe medications specified in public health programs and as part of a routine approved by the healthcare institution"⁽³⁾. Decree No. 94,406/1987 regulated this authority⁽⁴⁾, and Cofen Resolution No. 801/2026 consolidated national guidelines, without converting the prescription into an unrestricted authorization. The regulation linked this act to the nursing consultation within the scope of the Nursing Process, to clinical guidelines, and to institutional conditions⁽⁵⁾.

The Nursing Process organizes clinical reasoning into nursing assessment, nursing diagnosis, nursing planning, nursing implementation, and nursing evaluation⁽⁶⁾. Medication prescribing is an integral part of therapeutic planning and depends on the data obtained from the nursing assessment. The nursing diagnosis provides clinical justification for this nursing intervention, and the nursing follow-up allows for monitoring of response, adherence, adverse events, and the need for revision. This method ensures the quality and safety of medication prescribing.

The joint manual of the São Paulo Regional Nursing Council and the São Paulo State Regional Pharmacy Council outlines clinical, legal, and formal requirements for prescribing medications⁽⁷⁾. The document addresses protocols, prescription content, antimicrobials, dispensing, and electronic prescribing. It also clarifies the pharmacist's responsibility for technical and legal review prior to dispensing. This relationship does not transfer responsibility between professions but establishes successive checkpoints in the medication cycle, with patient safety as the guiding principle for the entire healthcare team.

In Primary Health Care, the prescribing of medications by nurses has historically been validated by government protocols that address regional health needs through actionable guidelines⁽⁸⁾. These protocols define indications, dosages, duration, referral criteria, and responsibilities. In this context, the São Paulo Municipal Health Department has published a series of Nursing Protocols organized into modules by life cycles and areas of care⁽⁹⁻¹²⁾. These documents provide guidance on consultations, ordering tests, interventions, and prescribing. However, the dispersion of recommendations across hundreds of pages can make it difficult to identify the set of medications available for nurses to use in practice.

The lack of a documented summary is an operational shortcoming that can limit the practice of registered nurses and the care provided to people seeking health care. Furthermore, during periods of high clinical pressure with limited consultation time, reviewing lengthy textual sections of protocols can increase the risk of omitting medications, doses, or restrictions. The sheer volume of content in protocols can also be a barrier to continuing education, making it challenging for professionals to stay up to date.

Given this, investigating the prescriptive content offers an opportunity to reflect on professional autonomy in the context of care. Clinical autonomy is not equivalent to normative

independence, since nurses make decisions within a field regulated by laws, protocols, demonstrated competence, and available resources. The scientific interest of this publication lies in describing this field and its constraints, rather than merely affirming the existence of legal competence.

Therefore, the objective of this scientific paper was to investigate the prescriptive content of the Primary Health Care Nursing Protocols of the São Paulo Municipal Health Department and to develop a reference matrix for medications that nurses are authorized to prescribe.

METHOD

Study Type and Reporting Guidelines

A qualitative literature review study, in which the document was treated as the unit of observation and each medication recommendation as the unit of record. To ensure greater transparency and reproducibility, the applicable items from the CARDA guideline, "Guiding Document Analyses in Health Professions Education Research"⁽¹³⁾, were used.

Study Population, Sample, and Setting

The population consisted of the document corpus limited to the Primary Health Care Nursing Protocols published by the São Paulo Municipal Health Department. The sample was a census and included four current modules made available for analysis. Module 1 addressed child and adolescent health. Module 2 addressed older adults. Module 3 addressed adults. Module 4 addressed women's health⁽⁹⁻¹²⁾.

The document unit was each protocol, and the context unit was the chapter, subchapter, figure, table, algorithm, flowchart, or note in which the prescription appeared. The record unit was each medication recommendation assigned to the nurse.

The analytical setting was the virtual documentation environment of the municipal primary care network; no data were collected at healthcare facilities.

Eligibility Criteria

Recommendations that included the name of a medication and explicit or contextual authorization for prescription by a nurse were included. Prescriptions described in tables, algorithms, flowcharts, symptom management guidelines, and public health programs were also included.

Pharmacological references used solely for educational purposes, therapeutic history, isolated contraindications, or exclusively medical treatment were excluded. Products without a defined active ingredient and non-pharmacological interventions were excluded from the study.

Data Collection

Data collection took place between October 2025 and February 2026. Initially, an electronic search of the records was conducted using the terms "medication," "prescribe," "prescription," "treatment," and "dose units." Next, the retrieved chapters and adjacent pages were read in their entirety. A second reading verified whether each item was associated with the nurse and identified conditions, doses, routes of administration, duration, warnings, and the need for continued medical care.

The data were recorded in a matrix with the following variables: protocol, page, clinical condition, active ingredient, association, dosage form, dose, route of administration, frequency, duration, population, prescribing modality, and

prescribing conditions. Names were standardized according to the Brazilian Common Name whenever possible. Combinations within the same formulation were counted as a single unit. The same active ingredient, when repeated in more than one module, was counted once in the general summary and retained in all indications in the analytical matrix.

Data Analysis

The categorical analysis was performed by two nurses specializing in Primary Health Care who have more than 20 years of practical experience in health services where the nursing protocols addressed in this study are in effect. The conditions were grouped into clinical evaluation, diagnostic confirmation, time limit, monitoring, contraindication, and referral. Discrepancies in spelling or dosage were verified against the original text. The study did not evaluate pharmacological appropriateness outside the protocols.

RESULTS

The protocols had a similar structure, including contextualization of health policies, nursing consultations, the nursing process, clinical conditions, interventions, prescriptions, referrals, and references. Medication recommendations were not concentrated in a single section. They were identified in clinical chapters, treatment tables, charts, algorithms, flowcharts, and notes.

The four nursing protocols totaled 1,055 pages; analysis of these documents identified 49 active ingredients or combinations with prescribing recommendations attributed to nurses. The adult module contained the greatest diversity, followed by the modules on women's health, children and adolescents, and older adults. Some medications appeared in more than one document, particularly analgesics, antiparasitic agents, topical antifungals, supplements, and rehydration solutions.

The 49 items were distributed across 12 therapeutic groups, with anti-infectives constituting the largest group. Next were cardiovascular medications, analgesics and antipyretics, supplements, and gastrointestinal medications. This distribution reflected the profile of the chapters. The women's health module focused on contraception, sexually transmitted infections, pregnancy, and menopause. The adult module covered chronic conditions, acute complaints, communicable diseases, and arboviral diseases.

Table 1 - Distribution of medications identified in the protocols, by therapeutic group, São Paulo (SP), Brazil, 2026.

Therapeutic group	n
Systemic and topical anti-infectives	13
Cardiovascular	12
Analgesics, antipyretics, and antispasmodics	4
Antidiabetics	3
Supplements and antianemic agents	4
Hormonal contraceptives	4
Non-anti-infective dermatologicals	3
Gastrointestinal and rehydration	2
Antiparasitic	3
Vaginal Menopause Therapy	1
Respiratory and nasal solutions	1
Antiplatelet agents	1

Source: Prepared by the authors (2026).

Prescribing practices were not uniform. Antihypertensives and antidiabetics were prescribed, in specific cases, as a continuation of the treatment plan initiated by the physician and for a limited

period. Medications for acute conditions, supplements, contraception, sexually transmitted infections, and arboviral infections were linked to the evaluation and criteria defined by the protocol. Antimicrobials required a syndromic or etiological diagnosis, allergy assessment, treatment of sexual partners, and referral when indicated.

The clinical record and the Nursing Process emerged as cross-cutting elements. The protocols linked subjective and objective data to diagnosis, planning, and implementation. Prescriptions were described within the care plan. Monitoring included clinical response, repeat tests, blood pressure, glycemic, and hematological control, or reassessment within a defined timeframe.

Table 1 - Identified medications and main prescribing contexts, São Paulo (SP), Brazil, 2026.

Group	Medications	Main Contexts
Cardiovascular	Spironolactone; furosemide; hydrochlorothiazide; atenolol; propranolol; captopril; enalapril; isosorbide mononitrate; amlodipine; nifedipine; losartan; methyldopa	Hypertension and treatment continuity, with assessment and time limit
Antidiabetic drugs	Glibenclamide; gliclazide; metformin	Diabetes, ongoing treatment, excluding insulin
Analgesics and antipyretics	Acetaminophen; dipyrrone; ibuprofen; scopolamine	Pain, fever, arboviral infections, cramps, and common complaints
Antiinfectives	Azithromycin; ceftriaxone; doxycycline; metronidazole; clindamycin; nystatin; miconazole; ketoconazole; fluconazole; itraconazole; acyclovir; cephalixin; benzathine penicillin G	Sexually transmitted infections, candidiasis, skin conditions, pediatric infections, and syphilis
Antiparasitic agents	Albendazole; ivermectin; permethrin	Helminthiasis, pediculosis, and scabies
Contraceptives	Ethinyl estradiol combined with levonorgestrel; norethisterone; medroxyprogesterone acetate; levonorgestrel	Regular and emergency contraception, as appropriate
Supplements and antianemic agents	Folic acid; ferrous sulfate; calcium carbonate; combined vitamins A and D	Preconception, pregnancy, childhood, and prevention of deficiency
Gastrointestinal and rehydration	Oral rehydration salts; mineral oil	Dehydration, diarrhea, and selected cases of constipation
Dermatological	Zinc oxide combined with vitamins A and D; topical dexamethasone; nasal sodium chloride	Dermatitis associated with incontinence, skin inflammation, and nasal hygiene
Menopause	Vaginal estriol	Genitourinary syndrome of menopause, with follow-up
Antiplatelet	Acetylsalicylic acid	Prevention of preeclampsia in pregnant women with risk factors

Source: Prepared by the authors (2026).

Prescribing safety considerations were identified in all modules. These included allergies, pregnancy, renal function, age, weight, cardiovascular risk, drug interactions, maximum dose, duration, and warning signs. For older adults, specific guidance was provided regarding medication reconciliation, polypharmacy, and drug interactions. For children, weight and age group determined dosages. In women's health, eligibility criteria guided contraceptive use, and risk factors determined the use of acetylsalicylic acid and calcium during pregnancy.

Traceability varied. Some tables listed the active ingredient, concentration, dosage, and duration. Others referred to the Municipal List of Essential Medications or to supplementary protocols. Repetitions, spelling differences, and recommendations distributed across separate chapters were observed. This characteristic underscores the utility of a single matrix for reference and updating.

The four protocols linked clinical practice to the nursing consultation, equating it with the Nursing Process. However, the relationship between nursing diagnosis and medication indication was not always presented directly. Prescription appeared mainly in the planning and implementation of care. Progress was associated with monitoring the clinical response, the occurrence of adverse effects, and the review of treatment approaches.

The documents defined medication prescribing as a conditional competency, rather than as unrestricted pharmacological authorization. The ability to prescribe depended on the clinical condition, the patient population, the criteria defined in the protocol, and the level of autonomy granted to the nurse.

The corpus also revealed the coexistence of autonomous prescriptions, shared decision-making, and situations reserved for physicians. This organizational structure defined professional boundaries within the care pathways.

DISCUSSION

The study identified a prescribing scope distributed across life cycles and clinical conditions. The main finding was not merely the quantity of medications. The documentary structure showed that prescribing takes on distinct forms. In some situations, the nurse initiates treatment according to established criteria. In others, the nurse maintains a previously defined therapy. This difference alters reasoning, documentation, and the need for interprofessional communication.

Brazilian legislation links these competencies to public health programs and institutional routines^(3,4). Cofen Resolution No. 801/2026 adds operational parameters and links prescribing to the Nursing Process⁽⁵⁾. Municipal protocols implement this authorization. Therefore, a list of medications should not be interpreted as a standalone form. Each item remains linked to the indication, the population, and the care pathway that supported its inclusion.

The presence of anti-infective agents requires attention, as the inappropriate use of antimicrobials increases adverse events and resistance. The World Health Organization considers antimicrobial resistance a significant threat and recommends programs for rational use⁽¹⁴⁾. The nurse's role includes assessment, selection in accordance with protocol, counseling, documentation, monitoring, and referral. The pharmacist contributes by reviewing prescriptions and providing counseling during dispensing⁽⁷⁾. This sequence facilitates the detection of errors but depends on communication and shared criteria.

Cardiovascular and antidiabetic medications were primarily prescribed as part of ongoing treatment. This approach can support access to care and long-term management of chronic conditions. It also requires clarity regarding clinical stability, test results, treatment goals, adverse events, and the schedule for medical reevaluation. Simply renewing a prescription does not align with the Nursing Process, which should be equivalent to a nursing consultation that evolves through the assessment of adherence, outcomes, clinical changes, and medication-related issues.

The elderly population requires additional safeguards, as pharmacokinetic changes, multimorbidity, and polypharmacy increase the risk of drug interactions and harm⁽¹⁵⁾. The protocol recommended a review of all medications used, including non-prescription ones. This recommendation brings the nursing consultation closer to medication reconciliation. A medication matrix should include alerts for duplication, renal function, hypotension, hypoglycemia, and prolonged use of potentially inappropriate medications.

In pediatric care, weight-dependent doses make prescriptions vulnerable to calculation errors and errors due to outdated weight information. Safety requires recording the measurement, available concentration, dose per kilogram, dosing interval, and maximum dose. Electronic prescribing systems can perform calculations, but they must display the formula and allow for verification. Automation without transparency creates dependence on the system and can perpetuate incorrect settings.

In women's health, the scope encompasses contraception, sexually transmitted infections, pregnancy, and menopause. Contraceptive eligibility criteria and obstetric risk factors demonstrate that medication is a consequence of a clinical classification. Nurses must recognize situations where the benefits outweigh the risks, as well as contraindications and the need for shared care. Prescribing vaginal estriol, for example, involves monitoring and evaluating changes.

The analyzed set also demonstrates how protocols function as governance tools. They standardize practices and provide support, but require version control. Legal changes, new evidence, updates to the Municipal List of Essential Medications, and public health alerts can render recommendations obsolete. A single repository, with an effective date and change history, would reduce inconsistencies across modules.

Digital transformation can improve traceability, since qualified electronic signatures, professional identification, and integration with electronic health records protect authorship and integrity^(5,7-8). Structured fields may require diagnosis, protocol, dose, duration, and a monitoring plan. Alerts should be specific and prioritized to avoid alert fatigue. Electronic prescribing should support clinical judgment, not replace it.

International studies indicate that prescribing by non-physician professionals can produce comparable results in selected contexts, although quality depends on training, scope, and service design^(1-2,16). The municipal analysis of protocols adds a local regulatory dimension. It reveals which medications have been incorporated into prescribing practices and which conditions limit the act. This knowledge allows for the evaluation of actual practices in subsequent studies.

Continuing education should combine pharmacology, clinical examination, nursing diagnosis, and communication. Training focused solely on filling prescriptions is insufficient. Simulated cases can assess medication selection, contraindications, dosage calculation, counseling, and follow-up. Audits can use indicators such as protocol documentation, completeness, reassessment, and adherence to criteria.

Analyzing prescribing modalities also helps avoid confusing autonomy with professional substitution. Initiating a protocol-based treatment requires an independent decision by the nurse, based on criteria and documented in the medical record. Therapeutic continuity requires confirming that the conditions of the previous treatment plan remain valid. Symptomatic management requires ruling out signs of severity and establishing a timeline for reassessment. Program-based prescribing depends on program rules, such as screening, contact tracing, supplementation, or prevention. These modalities may share the same prescription form but do not share the same decision-making process.

The completeness of the prescription constitutes only one aspect of safety. The prescriber's name, generic name, concentration, dosage form, route of administration, dose, frequency, duration, date, and prescriber identification are verifiable requirements. Clinical safety requires additional information in the medical record, including assessment data, diagnosis, rationale, instructions, warning signs, and a follow-up plan. Separating the prescription from the clinical record compromises understanding of the medical act. Electronic systems must maintain a link between the two and allow for auditing without manual reconstruction of the care provided.

Pharmaceutical dispensing serves as a subsequent safety barrier. The pharmacist verifies authenticity, legality, dose, duration, incompatibilities, and dispensing conditions. Any doubts should prompt contact with the prescriber, not unilateral alteration of the prescription. Interaction between nursing and pharmacy staff requires defined channels, response times, and criteria for returns. Shared protocols reduce discrepancies between what is prescribed and what can be dispensed in the public or private healthcare systems.

The presence of medications subject to specific health regulations requires operational attention. Antimicrobials have specific rules regarding retention, expiration, and record-keeping. Prescriptions for sexually transmitted infections may also involve treatment of sexual partners, reporting, and counseling. These components are part of the treatment plan. The availability of a medication at the facility does not replace verification of indications, allergies, drug interactions, pregnancy, renal function, or previous response. Rational use depends on consistency between diagnosis, treatment selection, and follow-up.

The survey showed that the same active ingredient may have different doses and durations depending on age, weight, condition, and therapeutic goal. Acetaminophen and dipyron appeared in several modules, but pediatric prescribing depends on weight, while adult prescribing uses dose ranges and maximum daily doses. Ferrous sulfate was used for both prevention and treatment, with distinct regimens. Standardization by active ingredient should preserve these variations. A list that omits context may lead to errors due to oversimplification.

Periodic updates must follow a formal method. Changes may be initiated by new regulations, changes in the drug formulary, pharmacovigilance alerts, drug shortages, or a review of the evidence. Each change requires an impact analysis, approval, communication, and an implementation date. Electronic systems, educational materials, and printed protocols must be updated simultaneously. The coexistence of different versions creates a risk of inconsistent prescribing and hinders accountability.

Competency assessment must consider both knowledge and performance. Theoretical tests can assess knowledge of legislation, pharmacology, and protocol interpretation. Clinical simulations can evaluate data collection, dose calculation, decision-making, communication, and record-keeping. Supervision and formative audits help identify error patterns. Institutional authorization must be accompanied by criteria for accreditation, updating, and reassessment, especially for medications with higher risk or low frequency of use.

The results also have implications for service-based research. The documentation matrix allows for the development of compliance indicators and the selection of samples from medical records. Future studies can measure the proportion of prescriptions with an identified protocol, dose appropriateness, presence of a diagnosis, timely reassessment, and occurrence of adverse events. They can also compare units, therapeutic categories, and prescribing practices. The analysis should avoid using prescription volume as a standalone measure of productivity.

The resulting summary can guide the development of an institutional list, but its implementation requires formal validation by the Municipal Health Department. Doses should not be copied into systems without pharmaceutical and clinical review. The corpus contains cross-references, editorial differences, and updates on different dates. Governance procedures must define who updates, approves, tests, and communicates changes.

Organizing the corpus by life cycles also reveals overlaps. Analgesics, antifungals, antiparasitics, and supplements appear in more than one module. This repetition may be necessary to make each protocol self-contained. However, it increases the likelihood of discrepancies when one section is updated and another remains unchanged. A cross-sectional layer of medications, linked to the clinical modules, could reduce duplication and preserve population-specific characteristics.

Terminological standardization is another issue. The documents used varying names for active ingredients, salts, concentrations, and dosage forms. For clinical use, the name must correspond to the available product and the Brazilian Common Name. For analysis, standardization must retain the original text and record the standardized form in a separate field. This strategy allows for tracing the source, comparing protocols, and preventing different medications from being grouped together due to similar names.

References to municipal lists and technical notes show that the protocol does not function in isolation. Prescribing decisions may depend on availability within the healthcare network, the version of the Municipal List of Essential Medications, epidemiological trends, and temporary guidelines. The support system must display the document in effect at the time of consultation. Broken links or files without version control reduce reliability and force the professional to seek information from alternative sources.

Pharmacovigilance should be integrated into the follow-up process, enabling nurses to identify adverse reactions, treatment failure, incorrect use, and drug interactions during subsequent consultations. Recording these events allows for a review of the plan and the submission of notifications when appropriate. Protocols and electronic systems should specify which signs require suspension of treatment, urgent evaluation, or notification to the referral service. The nursing follow-up is the point at which the initial decision is compared with the observed results.

Communication with the patient influences effectiveness, as guidance must include the purpose, method of use, duration, what to do if a dose is missed, expected effects, adverse events, and warning signs. For children and older adults, caregivers may participate, provided the patient is involved according to their capacity and autonomy. The language used should take into account health literacy, sensory barriers, and cultural context. A written prescription does not replace confirmation of understanding.

Equity must also be considered, bearing in mind that expanding access through nursing consultations can reduce wait times in areas with higher healthcare demand. This benefit depends on a regular supply of medications, training for healthcare professionals, and continuity of care. Without these components, the prescription may serve only as guidance without the possibility of implementation. Access indicators should include obtaining the medication, starting treatment, and follow-up visits—not just the issuance of the prescription.

Clinical governance must define responsibilities in exceptional situations. A shortage of the standard medication, allergies, contraindications, or previous treatment failure may require a therapeutic alternative. Nurses must know when the protocol authorizes substitution and when the case requires consultation with another healthcare professional. Flexibility without guidelines increases variability. Rigidity without provisions for exceptions can delay treatment. Decision flows must clearly outline options, limits, and support channels.

The integration of the matrix into electronic medical records must be tested prior to implementation. Test cases may include pediatric doses, duplicate prescriptions, allergies, pregnancy, renal function, and maximum duration. Validation must verify both the content and the system's behavior. Changes must go through an approval process and version control. Subsequent audits can identify ignored alerts, incomplete fields, and discrepancies between the generated prescription and the current protocol.

Documentary analysis does not replace the pharmacotherapeutic review of each recommendation. Some protocols were developed before subsequent standards were established or contain references with different dates. Harmonization must evaluate evidence, availability, safety, and consistency across modules. This work requires a formal institutional decision. The contribution of this study lies in making the content searchable and comparable, creating a basis for technical review rather than a parallel authorization of prescriptions.

The measurement of clinical outcomes must accompany any operational expansion. Blood pressure control rates, symptom resolution, adherence, and follow-up visits can be examined alongside adverse events and referrals. Comparisons must account for differences in population and severity. The goal is not to demonstrate productivity based on the number of prescriptions, but to verify whether prescribing integrated into the Nursing Process results in timely, safe, and coordinated care.

The matrix can also be used in university education. Pharmacology content should be linked to patient consultations, nursing diagnoses, and institutional protocols. Students need to understand that legal authority does not override institutional limits. Exercises using local protocols help students recognize criteria, calculate doses, and plan monitoring. The transition to practice requires supervision and ongoing training, as the scope of practice may vary across institutions.

Finally, user participation can enhance the review of protocols. Difficulties with understanding, access, administration, and feedback indicate issues not covered in regulatory analysis. Guidance materials should be tested with users and caregivers. Governance may include channels for reporting issues related to prescribing and dispensing. This data complements clinical audits and guides changes to the text, the electronic system, and the care pathway.

Document consolidation also promotes institutional transparency. Professionals need to access the current version, know the approval date, and identify relevant changes. Patients and pharmacists must recognize the legitimacy of the prescription. Publishing an annotated list—linked to protocols and without omitting the clinical context—can reduce uncertainty regarding scope. This resource should clarify that the presence of a medication on the list does not exempt it from consultation, documentation, risk assessment, follow-up, and documented interprofessional communication throughout the network.

Study Limitations

The analysis was limited to four protocols from a single municipality. The results do not describe all medications that can be prescribed by nurses in Brazil. The documents had different revision dates and levels of detail. Regulatory changes or subsequent updates may alter the identified scope.

The document analysis did not allow us to verify how prescriptions are issued in healthcare facilities, which medications are actually dispensed, or how professionals interpret ambiguous recommendations. Classifying the prescribing modality involved interpretation, particularly when the text did not directly identify the responsible professional. This risk was mitigated through operational definitions, contextual analysis, and review of decisions.

Contributions to Science

The study provides a taxonomy of the prescribing scope of nurses in a municipal primary care network. The distinction between initiation, continuation, programmatic prescribing, and symptomatic management enables research on quality and safety. The matrix can inform audit tools, continuing education curricula, and functional requirements for electronic prescribing. It also provides a basis for comparing protocols across municipalities and monitoring regulatory changes.

CONCLUSION

The analyzed protocols documented 49 active ingredients or combinations, distributed across 12 therapeutic groups. The scope included acute conditions, management of chronic diseases, sexual and reproductive health, pregnancy, childhood, and care for the elderly. Anti-infectives and cardiovascular medications constituted the largest groups.

Prescribing was linked to the medical consultation and the nursing process. The documents required assessment, diagnosis, planning, implementation, and follow-up. They also defined clinical criteria, duration, monitoring, and referral. Prescribing autonomy remained dependent on approved protocols, professional competence, and institutional structure.

Consolidation into a single matrix can reduce document fragmentation and support electronic systems. This matrix should include the indication, dose, target population, contraindications, prescribing modality, protocol version, and follow-up plan. Periodic institutional validation is recommended, involving nursing, pharmacy, medicine, patient safety, and information technology.

AUTHORS' CONTRIBUTION

Transparency in authors' contributions according to the [CRediT Taxonomy](#).

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Resources	Not applicable
Software	Not applicable
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SUPPLEMENTARY MATERIAL

The medication matrix was developed as supplementary material to compile, in a single document, the medication prescriptions identified in the Nursing Protocols of the São Paulo Municipal Health Department. Its organization follows the modules dedicated to the health of adults, women, older adults, and children and adolescents. For each entry, the medications, clinical indication, dosage or instructions, and the corresponding page in the source protocol were included.

The matrix preserves the specific characteristics of each documented recommendation. The same active ingredient may appear more than once when there are differences in indication, dose, duration, target population, or prescription modality. Situations involving therapeutic continuity, shared care, and referral were also retained, as these conditions define the clinical scope assigned to nurses in the analyzed documents.

This material is intended for traceability and document reference. It allows users to locate the recommendation in the original protocol and compare medications used across different life cycles and care pathways. The matrix should not be interpreted as an independent treatment form, a national list of authorized medications, or a substitute for the steps of the Nursing Process.

The clinical application of any item requires consultation of the current version of the protocol, individual assessment, documentation in the medical record, and compliance with institutional and professional standards. Updates to the Municipal List of Medications (REMUME), municipal ordinances, or the protocols themselves may modify indications, dosages, and treatment regimens. For this reason, the supplementary material should be used as a summary of the documents analyzed during the study period.

Matrix of “Medications” Prescribed by Primary Care Nurses of the São Paulo Municipal Health Secretariat
NURSING PROTOCOLS - SMS-SP 5th Ed. 2024/2025

MEDICATION	INDICATION	DOSAGE / GUIDELINES	PG
 >>  ADULT HEALTH			
<i>Amlodipine Besylate 5 mg, 10 mg (tablet)</i> <i>Atenolol 50 mg (tablet)</i> <i>Isosorbide 20 mg (tablet)</i> <i>Furosemide 40 mg (tablet)</i> <i>Hydrochlorothiazide 25 mg (tablet)</i> <i>Methyldopa 250 mg (tablet)</i> <i>Nifedipine 20 mg (tablet)</i> <i>Propranolol hydrochloride 40 mg (tablet)</i> <i>Captopril 25 mg (tablet)</i> <i>Enalapril maleate 5 mg, 20 mg (tablet)</i> <i>Spirolactone 25 mg, 100 mg (tablet)</i> <i>Losartan 50 mg (tablet)</i>	HAS	During a nursing consultation with a patient with hypertension, the antihypertensive medications listed in REMUME may be prescribed to continue the treatment plan proposed for this patient and already initiated by the physician. Please refer to SMS.G Ordinance No. 440 of 2023 All conditions covered in the protocols for Women's Health, Elderly Health, and Adult Health can be managed during the consultation for the management of hypertension, using nursing interventions and prescriptions contained in these protocols	111
<i>Gliclazide 60 mg (tablet)</i> <i>Metformin Hydrochloride 500 mg, 850 mg (tablet)</i>	DM	During a nursing consultation with a patient with diabetes, antidiabetic medications—EXCEPT FOR INSULIN—listed in REMUME may be prescribed, thereby continuing the treatment plan proposed by the physician for this patient. Please note SMS Ordinance G No. 440 of 2023	131
<i>Simvastatin 10, 20, and 40 mg (tablets)</i>	Dyslipidemia	Prescribe lipid-lowering medications listed in REMUME, continuing the treatment plan proposed for this patient by the physician	91
<i>Nicotine 7, 14, and 21 mg (patch)</i> <i>Nicotine 2 mg (lozenge/chewing gum)</i>	Smoking	Slow-release transdermal patch, fast-release chewing gum/lozenges. Consider 1 mg of nicotine for each cigarette and do not exceed the maximum dose of 42 mg/day. Check dosage and drug interactions in the protocol Prescribed by a certified nurse in a smoking cessation group	34, 35
<i>Nystatin 100,000 IU/mL (oral suspension)</i>	Oral candidiasis	4 mL orally every 6 hours for 14 days (keep in the mouth as long as possible)	70
<i>Acyclovir 50 mg/g (5%) cream, 200 mg (tablet)</i>	Cold Sores	Acyclovir cream 5 times a day for 5–7 days if it is the first episode with vesicles that began less than 72 hours ago, or in cases of extensive or recurrent ulcers	70
<i>Lidocaine 2% cream</i>	Pain	Apply to lesions every 8 hours as needed for pain relief	70
<i>Acetaminophen 500 mg (tablet), 200 mg/mL (drops)</i>	Pain and fever	Paracetamol 500–1000 mg every 6 hours	70, 281, 284, 291, 293, 295, 303, 312, 315, 350, 356, 360, 378, 397
<i>Sodium dipyrone 500 mg (tablet), 500 mg/mL (drops)</i>		Dipyrone 500–1000 mg every 6 hours	
<i>Ibuprofen 300 mg (tablet), 50 mg/mL (oral solution)</i>		Ibuprofen 300 mg (maximum dose of 2,400 mg/day) — 1 tablet every 8 hours for 5 days. Also start 2 to 3 days before the menstrual period	281, 284, 300, 303
<i>Scopolamine butylbromide 10 mg (tablet, drops)</i>	Menstrual cramps	Every 8 hours for up to 5 days	303
<i>Diclofenac 50 mg (tablet)</i>	Pain	Every 8 hours for up to 5 days. Also started 2 to 3 days before the menstrual period	303
<i>RHZE (rifampin 150 mg/ isoniazid 75 mg/ pyrazinamide 400 mg/ ethambutol 270 mg) (tablet)</i>	Tuberculosis	Weight 20–35 kg—Dose: 2 tablets; Weight 36–50 kg—Dose: 3 tablets; Weight 51–70 kg—Dose: 4 tablets; Weight > 70 kg—Dose: 5 tablets. Duration: 2 months (intensive phase/phase 1)	
<i>RH (full dose: rifampicin 300 mg/isoniazid 150 mg), (half dose: rifampicin 150 mg/isoniazid 75 mg) (tablet)</i>		Weight 20 to 35 kg - Dose: 1 tablet of 300/150 mg; Weight 36 to 50 kg—Dose: 1 tablet of 300/150 mg + 1 tablet of 150/75 mg; Weight 51 to 70 kg—Dose: 2 tablets of 300/150 mg; Weight > 70 kg. 2 tablets of 300/150 mg + 1 tablet of 150/75 mg. Duration: 4 months (maintenance phase/phase 2) NOTE: Treatment for bone tuberculosis and tuberculosis of the central nervous system lasts 12 months (2 months of phase 1 + 10 months of phase 2)	202
<i>Pyridoxine 40 mg (tablet)</i>		Treatment of tuberculosis in diabetic patients should be carried out using the basic regimen for at least 6 months, in combination with 40 mg of pyridoxine daily	217
<i>Sulfamethoxazole + trimethoprim 400 mg + 80 mg (tablet)</i> <i>Nitrofurantoin 100 mg (capsule)</i> <i>Norfloxacin 400 mg (tablet)</i> <i>Cephalexin 500 mg (capsules, tablets)</i>	UTI	Adults: 800 (sulfamethoxazole) + 160 (trimethoprim), PO, every 12 hours, for 3 days for women and 7 days for men (cystitis) Adults: Take 100 mg every 6 hours for 3 days (women) and 7 days (men); take with food Adults: 400 mg, PO, every 12 hours, for 3 days (E. coli, K. pneumoniae, or P. mirabilis) or for 7 to 10 days (other infections) Adults: 500 mg, PO, every 6 hours for 7 to 14 days	313 313 313 313
<i>Oral rehydration salts (powder)</i>	Dehydration	Dissolve the contents in 1 liter of filtered or boiled water and administer 100 to 150 ml per kilogram of body weight over a period of 4 to 6 hours.	318, 350, 361
<i>Permethrin 5% (lotion)</i>	Scabies	Wash off the lotion after 8–14 hours by taking a shower. Repeat after 7 days	331
<i>Ivermectin 6 mg (tablet)</i>	Scabies, Pediculosis, Tungiasis	Single dose (PO) — based on body weight (15–24 kg — 3 mg; 25–35 kg — 6 mg; 36–50 kg — 9 mg; 51–65 kg — 12 mg; 65–79 kg — 15 mg; ≥80 kg — 200 mcg/kg). Repeat in 7–10 days	331, 332, 333
<i>Permethrin 1% (scalp lotion)</i>	Head lice	Apply to the entire scalp, leave on for 10 minutes, and rinse	332
<i>Ketoconazole 20 mg/g (2%) (cream)</i>	Atopic dermatitis	Apply a sufficient amount of the product to cover the affected area, twice daily (morning and evening), for 7 to 14 days. Do not exceed 2 weeks of treatment	339
<i>Miconazole 20 mg/g [2%] (cream)</i>	Fungal infection, Pityriasis versicolor, Atopic dermatitis, Candida intertrigo	Apply enough to cover the affected area twice a day for 7 to 14 days	333, 334, 336, 339
<i>Fluconazole 150 mg (capsule)</i> <i>Itraconazole 200 mg (capsule)</i>	Candida intertrigo	If miconazole treatment fails or the condition is extensive. Adults: fluconazole 150 mg/week or itraconazole 200 mg, twice daily, for 2 to 6 weeks	338
<i>Albendazole 400 mg (tablet)</i>	Larva migrans	Albendazole 400 mg daily for 3 days (not to be used in pregnant women)	335
<i>ATA - 80% trichloroacetic acid</i>	Wart	Apply 80% TCA. Repeat every 7–10 days for up to 8 weeks. Isolate the wart	336
<i>Mineral oil (fr)</i>	Seborrheic dermatitis Constipation	Seborrheic dermatitis: Apply mineral oil to the affected area, leave it on for 15 minutes, then gently remove the scabs using a diaper, comb, or soft brush Constipation: 15 ml at night and 15 ml the next morning upon waking. If this is not effective, increase the dose to 30 ml (2 tablespoons)	337, 355

MEDICATION	INDICATION	DOSAGE / DIRECTIONS	PG
Zinc oxide 150 to 250 mg/g + retinol (vitamin A) + cholecalciferol (ointment)	Atopic dermatitis	Apply after each diaper change or as needed	339, 342
Metoclopramide hydrochloride 10 mg (tablet)	Gastrointestinal complaints	Metoclopramide 10 mg every 8 hours as needed for up to 5 days	350, 360, 378
Dimenhydrinate 50 mg	Nausea and vomiting	Every 6 hours	361
Aluminum hydroxide Oral suspension 60 mg/mL oral suspension (FR 100 mL)	Heartburn	5 ml (one teaspoon), PO, up to 3 times a day	365
Cynara scolymus L. (artichoke) 24 to 48 mg		2 tablets every 12 hours for six months	
Albendazole 400 mg (tablet) and 40 mg/mL (oral suspension)	Ascariasis Hookworm infection Enterobiasis or Oxyuriasis	400 mg/day (PO) single dose (Enterobiasis/Pinworm infection—repeat after 2 weeks)	369
	Trichuriasis Taeniasis	400 mg/day – orally every 24 hours for 3 days	
	Giardiasis	400 mg/day—orally. For 5 days	
		400 mg/day – taken orally 3 times a day. For 5 to 7 days	
Metronidazole 250 mg (tablet)	Amoebiasis	750 mg per dose—orally—3 times a day. For mild to moderate cases—5 days. For severe cases – 10 days	
 >>  WOMEN'S HEALTH			
Levonorgestrel 0.75 mg (tablet)	Emergency Contraception	Two tablets should be taken together as a single dose of 1.5 mg, up to 72 hours after sexual intercourse.	28.31
Levonorgestrel 0.15 mg + ethinyl estradiol 0.03 mg tablet, blister pack	Combined oral hormonal contraceptive	Preferably start on the first day of the menstrual cycle (bleeding), but it can be started up to the seventh day of the cycle (recommend using a barrier method for 7 days). See other instructions in the protocol	30
Norethisterone 0.35 mg	Progestin-only oral contraceptive	Start on the 1st day of the menstrual cycle (bleeding). See additional instructions in the protocol	30
Intrauterine Device	LARC	Intrauterine device for a duration specified by the manufacturer, inserted by a licensed nurse after training	31
Medroxyprogesterone acetate 125 mg + estradiol cypionate 5 mg injectable suspension	Contraceptive injectable hormonal	The first dose should ideally be administered by the 5th day of the menstrual cycle (counting from the start of bleeding). See additional instructions in the protocol	28
Medroxyprogesterone acetate 150 mg/mL injectable suspension			29
Algestone acetophenide 150 mg/mL + estradiol enanthate 10 mg/mL		The first dose should ideally be administered between the 7th and 10th day of the menstrual cycle (counting from the start of bleeding). See additional instructions in the protocol	29
Norethisterone enanthate 50 mg/mL + estradiol valerate 5 mg/mL solution for injection		Start on the 1st day of the menstrual cycle (bleeding). See additional instructions in the protocol	30
Metronidazole 250 mg (tablet)	Bacterial vaginosis, cytolytic trichomoniasis	First-line treatment: Metronidazole 250 mg, 2 tablets PO, twice daily, for 7 days. Recurrent cases: Metronidazole 250 mg, 2 tablets PO, twice daily, for 10 to 14 days	43, 44, 214
Metronidazole vaginal gel 100 mg/g		Metronidazole vaginal gel 100 mg/g, one full applicator vaginally, at bedtime, for 14 days Metronidazole vaginal gel 100 mg/g, one full applicator vaginally, at bedtime, for 14 days Recurrent cases: Metronidazole vaginal gel 100 mg/g, one full applicator, administered intravaginally, once daily for 10 days, followed by suppressive therapy with two applications () for 4 to 6 months	43, 44, 45, 133
Clindamycin 300 mg		Second-line treatment option: Clindamycin 300 mg, oral, twice daily, for 7 days	43
2% miconazole cream	Vulvovaginal candidiasis Candidiasis of the foreskin/glans	Miconazole 2% cream, vaginally, one full applicator, at bedtime, for 7 days. OR	44
Nystatin 100,000 IU		Nystatin 100,000 IU, one vaginal application at bedtime, for 14 days. Second treatment option: Fluconazole 150 mg, PO, single dose. OR Itraconazole 100 mg, PO, 2 tablets, twice daily, for 1 day.	
Fluconazole 150 mg		Recurrent cases: Miconazole 2% cream, vaginally, one full applicator, at bedtime, for 14 days. OR	
Itraconazole 100 mg		Fluconazole 150 mg, orally, once daily on days 1, 4, and 7, followed by maintenance therapy: Fluconazole 150 mg, orally, once weekly for 6 months	
Benzathine penicillin G	Primary syphilis, secondary, and recent syphilis (up to 2 years after exposure)	Treatment regimen: Benzathine penicillin G 2.4 million IU, IM, single dose (1.2 million IU in each buttock). Alternative regimen: Doxycycline 100 mg, PO, every 12 hours for 15 days. OR Ceftriaxone 1 g, IM or IV, once daily for 8 to 10 days	46, 143, 214
Ceftriaxone 1 g		Treatment regimen: Benzathine penicillin G 2.4 million IU, IM, weekly, for 3 weeks. Total dose: 7.2 million IU. Alternative regimen: Doxycycline 100 mg, PO, every 12 hours, for 30 days OR Ceftriaxone 1 g, IV or IM, once daily, for 8 to 10 days	46
Doxycycline 100 mg	Tertiary syphilis, Late latent syphilis Lymphogranuloma venereum	First-line treatment: Doxycycline 100 mg, 1 tablet, PO, every 12 hours, for 21 days Second-line treatment: Azithromycin 500 mg, 2 tablets, PO, once weekly for 21 days (first-line treatment for pregnant women) Sexual partners: Symptomatic sexual partners—treat with the same regimen as the index case. Asymptomatic sexual partners—Azithromycin 500 mg, 2 tablets, PO, single dose OR Doxycycline 100 mg, 1 tablet, PO, twice daily, for 7 days	47, 133
Azithromycin 500 mg (tablet)			
Ceftriaxone 500 mg		Gonorrhea, Chlamydia, and Soft Chancre Ceftriaxone 500 mg, IM, single dose + Azithromycin 500 mg, 2 tablets PO, single dose	46, 47, 48, 133, 214
Acyclovir 200 mg (tablet)	Genital herpes	Acyclovir 200 mg, 2 tablets PO, 3 times daily, for 7 days OR 1 tablet PO, 5 times daily, for 7 days - Start treatment as early as possible	48, 133
TCA - 80% trichloroacetic acid	HPV – Genital warts	Trichloroacetic acid (TCA) 80%–90% (solution). Usage: Apply a small amount only to the condylomas using a cotton applicator appropriate for the size of the lesions, and allow to dry until the lesion turns whitish. Once a week for up to 8 to 10 weeks. If the patient experiences severe pain, the acid can be neutralized with soap, sodium bicarbonate, or talcum powder	49, 134

MEDICATION	INDICATION	DOSAGE / INSTRUCTIONS	PG
<i>Doxycycline 100 mg (tablet)</i>	Donovanosis	First-line treatment: Doxycycline 100 mg, 1 tablet, PO, every 12 hours, for 21 days or until clinical remission of lesions. Second-line treatment: Azithromycin 500 mg, 2 tablets, PO, once a week for at least 3 weeks, or until the lesions have healed. OR Ciprofloxacin 500 mg, 1½ tablets, PO, every 12 hours, for at least 21 days or until the lesions have healed (total dose of 750 mg). OR Sulfamethoxazole-trimethoprim (400/80 mg), 2 tablets PO every 12 hours, for at least 3 weeks, or until the lesions have healed. OR Sulfamethoxazole-trimethoprim (800/160 mg), 1 tablet orally every 12 hours, for at least 3 weeks or until the lesions have healed. If there is no response within the first few days of ciprofloxacin treatment, add gentamicin 1 mg/kg/day, IV, 3 times daily for 3 weeks or until the lesions have healed (medical evaluation)	48, 49
<i>Azithromycin 500 mg (tablet)</i>			
<i>Ciprofloxacin 500 mg (tablet)</i>			
<i>Sulfamethoxazole + trimethoprim 400 mg + 80 mg (tablet)</i>			
<i>Ceftriaxone 500 mg</i>	Pelvic inflammatory disease	Ceftriaxone 500 mg, IM, single dose. + Doxycycline 100 mg, 1 tablet, PO, twice daily for 14 days. + Metronidazole 250 mg, 2 tablets, PO, twice daily for 14 days.	51, 52
<i>Doxycycline 100 mg (tablet)</i>			
<i>Metronidazole 250 mg (tablet)</i>			
<i>Paracetamol 500 mg (tablet), 200 mg/mL (drops)</i>	Breast pain	Prescribe acetaminophen 500 mg every 6 hours for 3 to 5 days OR ibuprofen 300–600 mg for 3 to 5 days; schedule a doctor's appointment if there is no improvement	72
<i>Sodium dipyrone 500 mg (tablet), 500 mg/mL (drops)</i>			
<i>Ibuprofen 300 mg (tablet) 50 mg/mL (oral solution)</i>			
<i>Folic acid</i>	Pregnancy	Folic acid—oral (0.4 mg/day). Prescription: Folic acid—oral solution (0.2 mg/mL)—prescribe 40 drops once daily Folic acid supplementation, at a dose of 0.4 to 0.8 mg/day, should be started at least one month before conception to support the formation of the embryo's neural tube and continued throughout pregnancy	99, 131
<i>Ferrous sulfate 40 mg of Fe⁺⁺ (tablet)</i>		Normal hemoglobin: Prophylactic supplementation with 40 mg of elemental iron: 1 tablet (indicating daily supplementation from the time pregnancy is confirmed until the end of pregnancy). Mild to moderate anemia: 200 mg/day of ferrous sulfate = 40 mg of elemental iron; prescribe two tablets one hour before breakfast, two tablets one hour before lunch, and one tablet one hour before dinner	122, 131
<i>Calcium Carbonate 1,250 mg (tablet)</i>		Calcium carbonate 1,250 mg, two tablets, taken orally, preferably at night with a glass of milk. Begin use at 16 weeks of gestation and continue through the 36th week of gestation.	131
<i>Acetylsalicylic acid (ASA) 100 mg (tablet)</i>		Acetylsalicylic acid (ASA) 100 mg, one tablet, taken orally once daily, preferably at night. Indicated for prevention in pregnant women at high risk of developing preeclampsia, with one high-risk factor or two moderate-risk factors. Treatment should be initiated starting at the 12th week (preferably before the 16th week, but may be started up to the 20th week) and continued through the 36th week	132
<i>Nitrofurantoin 100 mg (capsule)</i>	UTI during pregnancy	Antibiotic of choice for the treatment of asymptomatic bacteriuria and uncomplicated UTIs in pregnant women, prescribed by nurses: -Nitrofurantoin (100 mg), one capsule every 6 hours for 10 days (avoid after the 36th week of gestation); -Cephalexin (500 mg), one capsule every 6 hours, for 7 to 10 days; - Amoxicillin-clavulanate (500 mg), one capsule every 8 hours, for 7 to 10 days. • Note: Refer to the UTI Protocol	129, 133, 153, 154
<i>Cephalexin 500 mg (capsule, tablet, capsule)</i>			
<i>Amoxicillin 500 mg + Potassium Clavulanate 125 mg (capsule, tablet)</i>			
<i>Paracetamol 500 mg (tablet), 200 mg/mL (drops)</i>	Low back pain	Paracetamol 500 mg, every 6 hours	132
<i>Sodium dipyrone 500 mg (tablet), 500 mg/mL (drops)</i>	Pelvic pain Headache		
<i>Scopolamine butylbromide 10 mg (tablet, drops)</i>	Headache	Dipyrone 500 mg, every 6 hours	132
<i>Dimenhydrinate 25 mg/mL + pyridoxine hydrochloride (vitamin B6) 5 mg/mL</i>	Breast engorgement		
<i>Aluminum hydroxide Oral Suspension 60 mg/mL oral suspension (FR 100 mL)</i>	Colic	Scopolamine oral solution 10 mg/mL bottle: 40 drops twice daily or 10 mg tablet	132
<i>Nystatin 100,000 IU/mL (oral suspension)</i>	Nausea and vomiting	Dimenhydrinate 25 mg/mL + pyridoxine hydrochloride (vitamin B6) 5 mg/mL oral solution, drops—40 drops every 6 hours—(Do not exceed 400 mg/day). Risk B. Metoclopramide 10 mg, every 8 hours	132
<i>0.9% saline solution</i>	Heartburn	Aluminum hydroxide, 10–15 mL (two teaspoons to one tablespoon) after meals and at bedtime	
<i>Insect repellent (fr)</i>	Breast candidiasis	Prescribe for the postpartum woman: topical application of Nystatin for 14 days, after each feeding. Prescribe for the child: Nystatin oral solution—apply 1 dropper (1 ml) or 0.5 ml to each cheek of the child's oral mucosa, 4 times a day for 14 days	132, 172
<i>Estriol 1 mg/g</i>	Nasal congestion	Nasal saline solution: 2 to 4 drops in each nostril, 3 to 4 times a day, or as needed to keep the nostrils moist	132
	Nosebleeds		
	Aedes aegypti	Prevention of infections caused by Aedes aegypti (chikungunya, Zika, dengue, yellow fever). Apply to exposed areas of the body at least twice a day, or as often as necessary, according to the manufacturer's instructions	132
	Menopause	Hormone replacement therapy (topical vulvovaginal). Prescribe allopathic medication: Estriol 1 mg/g vaginal cream: 0.5 g/day, inserted twice daily for 14 days, followed by twice weekly for up to 3 months. Check blood pressure levels quarterly and monitor for changes	193
 >>  HEALTH OF THE ELDERLY			
<i>Spironolactone 25 mg or 100 mg</i>	Hypertension	During a nursing consultation with a patient with hypertension, antihypertensive medications listed in REMUME may be prescribed to continue the treatment plan proposed for this patient and already initiated by the physician. Note: In accordance with COREN Opinion No. 058/2013, within the SMSSP Primary Care network, a nurse may, following an assessment during a nursing consultation, prescribe medications for continuous use until the next medical appointment, not to exceed 180 days, as per ADMINISTRATIVE ORDER No. 338/2014-SMS.G	44
<i>Hydrochlorothiazide 25 mg</i>			
<i>Atenolol 50 mg</i>			
<i>Propranolol 40 mg</i>			
<i>Captopril 25 mg</i>			
<i>Enalapril 5 mg or 20 mg</i>			
<i>Isosorbide 20 mg</i>			
<i>Amlodipine 5 mg or 10 mg</i>			
<i>Nifedipine 20 mg</i>			
<i>Losartan 50 mg</i>	Diabetes Mellitus	According to page 70 of the adult health nursing protocol: during the nursing consultation, antidiabetic medications—EXCEPT FOR INSULIN—listed in REMUME may be prescribed, thereby continuing the treatment plan proposed for this patient. Maximum duration of up to 180 days	44
<i>Glibenclamide 5 mg</i>			
<i>Glicazide 60 mg</i>			
<i>Metformin 500 mg or 850 mg</i>			

MEDICATION	INDICATION	DOSAGE / GUIDELINES	PG
Paracetamol 200 mg/mL or 500 mg/tablet	Pain Management	Every 4/4 hours or 6/6 hours, depending on the frequency of pain. Adults: 500–1000 mg per dose. (maximum of 4 g per day)	44
Dipyrone solution, 500 mg/mL, or 500 mg/tablet		Every 6 hours, depending on the frequency of pain. Adults: 500–1000 mg orally (max 4 g/day)	
Ibuprofen (300 mg/tablet or 50 mg/mL)		Up to 600 mg PO every 8 hours. Maximum dose: 2,400 mg/day	
Zinc oxide 150 mg/g + vitamin A 5,000 IU/g + vitamin D 900 IU/g, 45-g tube ointment	Ammonia-induced dermatitis/ Diaper dermatitis/ Dermatitis Associated with Incontinence (DAI)	Apply after each diaper change or as needed	44
Nystatin 100,000 IU tube		Apply a sufficient amount of the product to cover the affected area after each diaper change for 5 days. Apply only in the presence of Candida infections	
Miconazole nitrate 2% cream, minimum 20 g		Apply a sufficient amount of the product to cover the affected area, twice daily (morning and evening), for 7 to 14 days. Apply only in the presence of Candida infections. Should not be used for periods longer than two weeks	45
Ketoconazole 2% cream (20 mg/g), 30-g tube		Apply a sufficient amount of the product to cover the affected area, twice daily (morning and evening), for 7 to 14 days. Apply only in the presence of Candida infections. Do not use for periods longer than two weeks	
Dexamethasone acetate 0.1% (1 mg/g) cream, 10-gram tube.		Apply a thin layer of the product to the area to be treated, 1 or 2 times a day, no more than twice a day, to relieve inflammation. Use with caution and provide clear instructions to family members not to exceed the recommended duration of use. Absorption through the skin may result in more serious adverse effects (similar to those of systemically administered corticosteroids).	
Pure mineral oil, 100 mL.	Constipation	Adults: 15 mL at night and another dose the next morning upon waking. If this is not effective, increase the dose to 30 mL (2 tablespoons) at night and 15 mL in the morning. Warning: May cause lipid pneumonia, malabsorption of fat-soluble vitamins, dehydration, and fecal incontinence	45
Oral Rehydration Salts (27.9 g Envelope)	Dizziness and Vertigo (Postural Hypotension)	Dissolve the contents of the packet in one liter of filtered or boiled water. Administer 100 to 150 mL per kilogram of body weight over a period of 4 to 6 hours	45
Permethrin 5% Topical Lotion	Scabies	Apply the lotion from the neck down, including the palms of the hands and soles of the feet, between the toes, the periumbilical area, the genital area (do not apply to mucous membranes), and under the fingernails; remove the lotion after 8–14 hours by showering. Repeat the application after 7 to 10 days; Examine and treat people in close contact with the patient; Residual itching may persist for 2 to 4 weeks after treatment	45
Ivermectin 6 mg tablet	Scabies and Pediculosis	Dose of 200 mcg/kg; Repeat the single oral dose in 7 to 10 days; Instruct the patient to take the medication with water; fasting is not required. Refer to the protocol for dose calculations	46
Permethrin 1% topical lotion	Head lice	Apply to the scalp, especially behind the ears and on the nape of the neck; leave on for 5–10 minutes, then rinse with warm water. Repeat the procedure after 7 days. Examine and treat individuals who have had close contact with patients.	46
Miconazole nitrate 2% cream, at least 20 g	Tinea corporis (ringworm of the body) and Tinea pedis (athlete's foot or athlete's foot)	Apply to the entire affected area twice daily (morning and evening) for 7 to 14 days. This product should not be used by patients with hypersensitivity to any of the ingredients. Do not apply near the eyes. If lesions are extensive, systemic antifungal treatment may be necessary. Refer to a physician	46
Albendazole 400 mg	Ascariasis, Hookworm Infection, Enterobiasis, or Pinworm Infection	1 tablet per day for 3 days	46
	Taeniasis, Trichuriasis	1 tablet daily for 5 days	
	Giardiasis	One-day treatment, repeated after 7 days	
Estriol 1 mg/g (0.1%) gynecological cream, 50 g tube + applicator	Vaginal dryness	Insert 0.5 g of vaginal cream daily for 21 days and repeat if necessary (maximum treatment duration: up to 3 months) For menopausal women with recurrent urinary tract infections, if symptoms persist, refer to a physician	46
Mikania glomerata Spreng (guaco) oral solution containing 0.02 to 5 mg of coumarin	Persistent cough and cough with sputum	Oral: Adults—15 mL 3 times daily for 7 days. Contraindications: Liver disease, as chronic use may cause an increase in prothrombin time. Do not use during pregnancy, while breastfeeding, or in individuals under 18 years of age. Do not use for more than 15 consecutive days; treatment may be repeated, if necessary, after a 5-day interval. Do not use while taking nonsteroidal anti-inflammatory drugs (NSAIDs) or concurrently with anticoagulants (coumarins reduce blood clotting)	47
Maytenus ilicifolia (espinheira santa) total tannins 13 mg to 20 mg (tablet)	Indigestion and as an adjunct in the treatment of stomach and duodenal ulcers	Oral use—minimum dose: 1 tablet orally twice daily. Maximum dose: 2 tablets three times daily. Contraindications/warnings: Use is contraindicated for individuals under 18 years of age, during pregnancy, and while breastfeeding, as it reduces breast milk production and may cause uterine contractions. If used continuously, administer for 3 months and then take a 1-month break	47
Harpagophytum procumbens (devil's claw) harpagoside 5 mg or 50 mg (tablet)	Arthritis, osteoarthritis, and treatment of lower back pain	Take orally 3 times a day, adhering to the daily dose of 30 to 100 mg of harpagoside (RENAME/2024 and IN No. 02/2014 – ANVISA). Contraindications/warnings: Use is contraindicated during pregnancy and breastfeeding, and for individuals with gastric or duodenal ulcers, cardiovascular disease, or those under 18 years of age. Avoid use in combination with anticoagulants	47
Glycine max (L.) Merr. Soy Isoflavones Total Isoflavones: minimum of 50 mg (tablet)	Menopause	Adjuvant in relieving menopausal symptoms: reduction in the frequency and intensity of hot flashes in the body and face, as well as night sweats Oral use: Take once daily, adhering to the daily dose of 50 to 120 mg of isoflavones (RENAME/2024 and IN No. 02/2014 – ANVISA). For continuous use, take for 3 months and then take a 1-month break	47
Valeriana officinalis sesquiterpenes 0.8 mg to 3.5 mg (tablet)	Moderate sedative	Moderate sedative, used as a sleep aid and in the treatment of anxiety-related sleep disorders Oral use - Mild anxiolytic - Take at night, at least 1 hour before bedtime, adhering to the daily dose of 1 to 7.5 mg of sesquiterpenes (IN No. 02/2014 – ANVISA). Effects begin within 2 weeks. Minimum treatment duration: 4 weeks	47
Cynara scolymus L. (artichoke) caffeoylquinic acid derivatives 24 to 48 mg (per capsule)	Relieves gastric discomfort	To aid digestion and relieve abdominal discomfort. Gas and nausea resulting from impaired bile production and excretion. Also helps lower blood cholesterol levels. Oral use: Take according to the daily dose of 24 to 48 mg of caffeoylquinic acid derivatives, expressed as chlorogenic acid, in up to 3 doses per day. The duration of treatment for the indication as a choleretic/cholagogue is 2 weeks. The duration of treatment for the indication as an adjunctive cholesterol-lowering agent is 6 to 12 weeks. Contraindicated for individuals with gallstones, bile duct obstruction, cholangitis, or liver disease. Do not use while taking anticoagulants	48

MEDICATION	INDICATION	DOSAGE / GUIDELINES	PG
CHILD AND ADOLESCENT HEALTH			
Vitamins A and D	Preventive measure	Administer as a supplement starting on the 7th day of life: 2 (two) drops by mouth daily until the child turns two years old, and 3 (three) drops daily between two and three years of age, as a preventive measure	69
Ferrous Sulfate—oral solution 25 mg/mL (1.25 mg/drop)	Prophylactic measure for iron-deficiency anemia	Full-Term Infants: Full-term newborns with weight appropriate for gestational age, regardless of feeding method, should be prescribed 1 mg of elemental iron/kg/day, starting at 90 days of age and continuing until the 24th month of life. Full-term newborns weighing less than 2,500 g: prescribe 2 mg of elemental iron/kg/day, starting at 30 days of age, for one year. After this period, 1 mg/kg/day for another year. For preterm newborns weighing more than 1,500 g, prescribe 2 mg of elemental iron/kg/day, starting at 30 days of age, for one year. After this period, 1 mg/kg/day for another year. For preterm newborns weighing between 1,500 and 1,000 g, prescribe 3 mg of elemental iron/kg/day, starting at 30 days of age for one year. After this period, 1 mg/kg/day for another year. For preterm newborns weighing less than 1,000 g, prescribe 4 mg of elemental iron/kg/day, starting at 30 days of age, for one year. After this period, 1 mg/kg/day for another year. Preterm infants who received more than 100 mL of packed red blood cells during hospitalization should be evaluated individually, as they may not require iron supplementation at 30 days of age, but rather at a later stage	68, 69
Ferrous sulfate 125 mg/mL (equivalent to 25 mg/mL of Fe++) oral solution, drops	Anemia	3 to 6 mg elemental iron/kg/day for 6 months or until body stores are replenished, as confirmed by normalization of Hb, MCV, MCH, serum iron, transferrin saturation, and serum ferritin. Administer 30 minutes before meals, along with juices rich in vitamin C, and brush teeth afterward	112
Miconazole 20 mg/g (2%) cream	Tinea pedis (athlete's foot or chilblains)	Apply a sufficient amount of the product to cover the affected area twice daily for 7 to 14 days	76
Paracetamol 200 mg/mL or 500 mg/tablet, or Dipyron solution drops 500 mg/mL or 500 mg/tablet, or Ibuprofen 50 mg/mL.	Hand, Foot, and Mouth Disease	Paracetamol 200 mg/mL or 500 mg/tablet—1 drop/kg every 4/4 hours or 6/6 hours, depending on the frequency of pain. Children: 10–15 mg/kg per dose (maximum of 5 doses per day) — Note: (maximum of 4 g per day). OR Dipyron solution drops 500 mg/mL or 500 mg per tablet — 1 drop per kg every 6 hours, depending on the frequency of pain. Children > months: infants 10 mg/kg/dose and preschoolers 15 mg/kg/dose - Note: (maximum of 4 g/day). OR Ibuprofen 50 mg/mL - 1 drop/kg every 6 hours (children over 6 months)	77
Miconazole 20 mg/g (2%) cream	Tinea corporis (ringworm)	Apply a sufficient amount of the product to cover the affected area twice daily for 7 to 14 days	78
	Miliaria	Rinse the child after bathing with: 1 liter of water mixed with 2 tablespoons of cornstarch 3 times a day; or apply the cornstarch directly to the skin as if it were talcum powder; or apply a water-based paste 3 times a day after bathing if the condition is of the erythematous and/or deep forms	78
Topical ketoconazole (2%) or miconazole 20 mg/g (2%) cream	Pityriasis versicolor	Topical ketoconazole (2%) - Apply to the entire neck, trunk, arms, and legs once or twice a day for 2 weeks. OR Miconazole 20 mg/g (2%) cream - Apply a sufficient amount of the product to cover the affected area and extend beyond the lesion, twice a day, for 7 to 14 days	79
	Pityriasis Alba	Advise the patient to avoid using soaps and other scented products or clothing that may irritate the skin. Recommend daily use of broad-spectrum sunscreen on sun-exposed areas to prevent worsening of the lesions and avoid post-inflammatory hyperpigmentation. Recommend moisturizing and hydrating the skin with emollient creams	
Albendazole 40 mg/mL Oral Suspension	Larva Migrans	For children aged 1 to 2 years, prescribe 200 mg PO once daily for 3 days; for children over 2 years of age and adults, prescribe 400 mg PO for 3 days	80
Cephalexin 50 mg/mL oral suspension (mg/kg/day)	Impetigo	Cephalexin 50 mg/mL oral suspension (mg/kg/day) every 6 hours for 7 days. - Multiply the weight in kg by 50 mg/mL, divide by 4, and then divide again by 50 mg/mL. The result will be the dose in mL every 6 hours	80
Ivermectin 6 mg tablet: Dose of 200 mcg/kg; single dose	Tungiasis (Foot Worm)	Be sure to calculate the dosage according to the protocol	81
Permethrin 5% (cream/lotion)	Scabies	> 2 years of age. Single dose at night. Leave on for 8 to 12 hours. Repeat in 7 days	81
Ivermectin 6 mg tablet		Dose of 200 mcg/kg; • Repeat the single oral dose in 7 to 10 days; pay close attention to dose calculation	82
Permethrin 1% (scalp lotion)	Head lice	> 2 years of age. Apply to the scalp for 10 min. and rinse. Repeat in 7 days	83
Ivermectin 6 mg tablet: Dose of 200 mcg/kg; single dose		Ensure the dose is calculated correctly; repeat the single oral dose in 7 to 10 days	83
Apply 80% ATA.	Common Warts:	Provide guidance, recommending a medical evaluation. Medication: Apply 80% ATA. Repeat every 7–10 days for up to 8 weeks. Try to isolate the wart during application to avoid contact with healthy skin; one option is to cover it with adhesive tape	84
bottle of mineral oil (or petroleum jelly)	Seborrheic Dermatitis	Apply to the scalp, leave on for 1 hour, and gently remove with a fine-toothed comb	53
Miconazole nitrate 20 mg/g (cream)*	Monilia/Candida dermatitis	Apply after each diaper change for 7–10 days *(prescribe the product available through REMUME)	85
Nystatin 100,000 IU tube		Apply a sufficient amount of the product to cover the affected area after each diaper change for 5 days.	
Ketoconazole 20 mg/g (2%) cream		Ketoconazole 20 mg/g (2%) cream - Apply a sufficient amount of the product to cover the affected area, twice daily (morning and evening), for 7 to 14 days. Do not exceed 2 weeks of treatment.	
Zinc oxide 150 to 250 mg/g + retinol (vitamin A) + cholecalciferol (ointment)	Diaper Rash	After each diaper change and as needed	86
Mineral oil or almond oil	Seborrheic Dermatitis	Apply mineral oil or almond oil to the affected area, leave on for 15 minutes, gently remove the crusts using a diaper, comb, or soft brush, wash the skin thoroughly with mild soap or baby shampoo to remove all the oil, and dry the skin thoroughly. • If symptoms persist for more than 15 days or spread, consult a doctor	
Zinc oxide 150 to 250 mg/g + retinol (vitamin A) + cholecalciferol (ointment)	Intertrigo (Intertriginous rash)	Apply cornstarch directly to the skin or use a zinc oxide cream with vitamins A and D	

MEDICATION	INDICATION	DOSAGE / DIRECTIONS	PG
Oral Rehydration Salts (powder)	Acute Diarrhea	Dilute in 1 L of water. Take after watery stools (Children Up to 4 months < 6 kg 200 to 400 ml, 4 to 11 months 6 to < 10 kg 400 to 700 ml, 12 months to 2 years: 10 to < 12 kg: 700 to 900 ml; 2 to 5 years: 12 to 19 kg: 900 to 1,400 ml)	92
Mebendazole 20 mg/kg Albendazole 400 mg	Ascariasis	Over 10 kg Over 2 years of age 100 mg (5 mL) once daily for 3 days—1 tablet or 10 mL orally as a single dose. Repeat after 3 weeks	97
Albendazole 400 mg	Trichocephalosis	Over 2 years of age: 10 mL as a single dose or 1 tablet orally, once daily for 3–7 days. Side effects: abdominal pain, headache, diarrhea, nausea, and vomiting	97
Mebendazole 100 mg	Hookworm infection	Over 10 kg, once daily for 3 days. Repeat in 3 weeks.	97
Mebendazole 100 mg	Enteroglyosis or pinworm infection	Dose for all children regardless of weight and age: once daily, single dose; repeat in 2 weeks. Treat all children in the household	97
Albendazole 400 mg	Strongyloidiasis	Over 2 years of age: Oral, twice daily for 10 to 14 days (4 days on, 4 days off). Treat all children in the household	97
Mebendazole 20 mg/mL or Albendazole 400 mg	Taeniasis	Over 2 years of age: 10 mL twice daily for 3 days—1 tablet orally as a single dose. Treat all children in the household	97
Metronidazole	Giardiasis	Over 2 years of age: 15 mg/kg/day (maximum 250 mg) orally twice daily for 5 days	97
Metronidazole—do not exceed 750 mg per dose	Amoebiasis	Over 2 years of age: 35 mg/kg/day, 3 times daily for mild cases for 5 days. Extraintestinal or symptomatic: 50 mg/kg/day for 10 days	97
Mikania glomerata (Guaco) syrup 0.25 mg/mL	Cough	Sodium Chloride Nasal Solution 9 mg/mL (0.5 to 3 mL 4 to 6 times a day) in each nostril, preferably before feedings and meals and before bedtime; Mikania glomerata (Guaco) syrup 0.25 mg/mL: Children 3 to 5 years old – 5 mL, 3 times a day; Children > 5 years old – 7.5 mL, 3 times a day. Pay attention to contraindications	104, 106
Paracetamol 200 mg/mL	Acute pain; pain in the paranasal sinus region; headache; fever; earache	1 drop/kg every 6 hours for 3 days	104, 108, 110
Ibuprofen 50 mg/mL	Fever, earache	1 drop/kg every 6 hours (For children under 3 months or at any age with a temperature above 39, refer to a doctor)	108, 110
Dipyrone 500 mg/mL		1 drop/kg or 10 to 15 mg/kg. Minimum 6-hour interval for children over 3 years of age, for up to 3 days. Check the child for drug allergies. Consult with the doctor	104
Paracetamol 200 mg/mL or 500 mg/tablet	Sore throat, earache	Every 4/4 hours or 6/6 hours, depending on the frequency of pain. Adults: 500–1,000 mg/dose Children: 10–15 mg/kg/dose (maximum of 5 doses per day) — Note: (maximum of 4 g/day). Follow up in 24/48 hours if symptoms worsen	106, 110
Dipyrone solution, drops 500 mg/mL or 500 mg/tablet	Fever, Earache	Every 6 hours, depending on the frequency of pain. Adults: 500–1000 mg PO. Children > months: infants 10 mg/kg/dose // preschoolers 15 mg/kg/dose — Note: (maximum 4 g/day)	106, 110, 111
Nystatin oral suspension 100,000 IU/mL	Oral candidiasis	Prescribe 1.0 mL on the oral mucosa four times a day for seven days; apply half the dose to each side of the mouth. Continue the regimen for at least two days after symptoms have resolved	151
Benzathine penicillin G	Syphilis	Adults and adolescents weighing more than 45 kg: 2.4 million IU, IM (1.2 million IU in each buttock). Children and adolescents weighing less than 45 kg: 50,000 IU/kg, IM. For prophylaxis and in cases of recent syphilis, it should be prescribed as a single dose	237
Ceftriaxone + Azithromycin	Infection caused by N. gonorrhoeae, , and C. trachomatis	Adults and adolescents weighing more than 45 kg: 500 mg, 1 vial, IM, single dose + 500 mg, 2 tablets of 250 mg, PO, single dose. Children and adolescents weighing less than 45 kg: 125 mg, IM, single dose + 20 mg/kg, PO, single dose	
Metronidazole	Trichomoniasis	Adults and adolescents weighing more than 45 kg: 500 mg, 2 tablets of 250 mg, oral, single dose; 15 mg/kg/day, divided every 8 hours, for 7 days. Should not be prescribed during the first trimester of pregnancy. Its use should be postponed in cases of emergency contraception or antiretroviral (ARV) therapy	

Excerpted from Nursing Protocols, 5th revised edition (2024/2025). https://prefeitura.sp.gov.br/web/saude/w/atencao_basica/349991.

SMS.G Ordinance No. 440 of 2023, which establishes guidelines for the prescription and dispensing of medications within facilities belonging to the Unified Health System (SUS) under municipal management and recognizes nurses as prescribers. <https://legislacao.prefeitura.sp.gov.br/leis/portaria-secretaria-municipal-da-saude-sms-440-de-18-de-julho-de-2023>.

REMUME—Municipal List of Medications. https://prefeitura.sp.gov.br/web/saude/w/atencao_basica/218750

NOTE: This material is a supplementary document subject to change; therefore, under no circumstances does it replace consultation of nursing protocols.

Material prepared by Specialist Nurse Tatiana Lucena, under the supervision of Professor Dr. Abel Meneses, RN