preferable to the intramuscular route. However, intramuscular absorption may be more clinically efficacious than the intranasal route in the presence of significant rhinorrhea

f. The patient should be emergently transported to the closest appropriate medical facility as directed by medical direction

3. **Recommended Doses** (See dosing tables)

The medication dosing tables that are provided below are based upon the severity of the clinical signs and symptoms exhibited by the patient. There are several imperative factors to note:

a. For organophosphate or severe acetylcholinesterase inhibitor agent exposure, the required dose of atropine necessary to dry secretions and improve the respiratory status may exceed 20 mg. Atropine should be administered rapidly and repeatedly until the patient's clinical symptoms diminish. Atropine must be given until the acetylcholinesterase inhibitor agent has been metabolized.

b. Because Duodote® auto-injectors contain pralidoxime chloride, they should not be used for additional dosing of atropine beyond the recommended administered dose of pralidoxime chloride

c. All the medications below can be administered intravenously in the same doses cited for the intramuscular route. However, due to the rapidity of onset of signs, symptoms, and potential death from acetylcholinesterase inhibitor agents, intramuscular administration is highly recommended to eliminate the inherent delay associated with establishing intravenous access

d. The antidotes can be administered via the intraosseous route. However, due to the rapidity of onset of signs, symptoms, and potential death from acetylcholinesterase inhibitor agents, intramuscular administration remains the preferable due to the inherent delay associated with establishing intraosseous access and the limited use of this route of administration for other medications