Enclosure No:	5/AWMSG/0526
Agenda item No:	9 – All Wales gabapentinoid resources for chronic pain
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1.0 Action for AWMSG

AWMSG members are asked to consider the enclosed *All Wales gabapentinoid resources for chronic pain* document for endorsement. Consultation responses received in February 2026 and resulting actions are summarised at the end of the document. AWTTC's equality and health impact assessment form is also enclosed.

2.0 Purpose

Prescribing of gabapentinoids (gabapentin and pregabalin) has continued to increase despite the introduction of a National Prescribing Indicator in 2017 and their reclassification as Schedule 3 controlled drugs in 2019. Gabapentinoids are widely prescribed for a range of pain conditions, although very limited evidence supports their use outside neuropathic pain. Concerns have also increased regarding their safety and associated harms, including a rise in deaths in which pregabalin has been recorded on death certificates in Wales and a substantial increase in gabapentinoid-related enquiries to the Welsh National Poisons Unit. In response to these concerns, the *All Wales gabapentinoid resources for chronic pain* has been developed through extensive engagement with the Gabapentinoid Task Force. The task force is a multidisciplinary group with representation from all Welsh health boards and includes pain specialists, pharmacists, clinicians, GPs, physiotherapists, and substance misuse specialists.

The resources aim to support healthcare professionals and patients in shared decision-making about the use of gabapentinoids in the management of chronic pain. There are four resource packs, which may be used either individually or collectively. The resource materials provide practical guidance on appropriate use, monitoring, and deprescribing, support balanced consideration of potential benefits and harms, and encourage a holistic approach to pain management.

The resources are pertinent to the following ambitions set in the AWMSG Strategy for Wales: 2024–2029:

- Help people in Wales get the best outcomes from medicines
- Minimise medicines-related harm and improve medicines-related safety for people in Wales

2.1 Process

- December 2025: Draft document considered by AWPAG
- January–February 2026: Draft document out for consultation
- March 2026: Consultation comments and responses considered by AWPAG for sign-off
- *May 2026: Document presented to AWMSG for endorsement*

2.2 Consultees

Consultees include, but are not limited to:

- Directors of Pharmacy
- Medical Directors
- Assistant Medical Directors
- Health Board Chief Executives
- Directors of Nursing
- Local Medical Committees
- Directors of Public Health
- General Practitioners Committee (GPC) Wales
- Royal College of General Practitioners (RCGP)
- British Medical Association (BMA) Cymru
- Llais Cymru
- Community Pharmacy Wales (CPW)
- Public Health Wales (PHW)
- Welsh Government
- NHS Wales Joint Commissioning Committee (JCC)
- National Institute for Health and Care Excellence (NICE)
- AWMSG members and deputies
- AWPAG members and deputies

3.0 Summary

The *All Wales gabapentinoid resources for chronic pain* have been developed to support healthcare professionals in the appropriate prescribing, review, and deprescribing of gabapentinoids for chronic pain. The resources are split into five packs and provide practical guidance to support shared decision-making with patients, promote a holistic approach to chronic pain management, and reduce inappropriate prescribing. Each resource pack can be used on its own or alongside the others to support discussions with patients.

Members of the task force include Dr Faye Graver, Christina Birkby, Dr Emma Davies, Robert Bevan, Bethan Thain, Rhian Owen, Dr Rhian Hills, Rhodri Parfitt, Tammie Ng, Dr Sunil Dasari, Dr Gemma Rogers, Simon Gill, and Ceri Clatworthy.

Contents

Glossary

Addiction
A state in which an individual develops physical or psychological reliance on a medicine, often associated with craving, loss of control over use, continued use despite harm, misuse or abuse, and withdrawal symptoms on cessation.

Chronic pain
Pain that persists or recurs for longer than three months. Chronic pain is multi-factorial: biological, psychological and social factors can contribute to the pain experience. It can include low back pain and arthritis and can sometimes develop from acute pain that persists. Chronic pain may be classified as *chronic primary pain* or *chronic secondary pain*.

Chronic primary pain
Chronic primary pain in which no underlying condition adequately accounts for the pain or its impact. Potential chronic primary pain diagnoses include chronic widespread pain or fibromyalgia; chronic primary musculoskeletal pain; chronic primary visceral pain; and complex regional pain syndrome. Gabapentinoids are not recommended for chronic primary pain due to lack of evidence of benefit.

Chronic secondary pain
Pain caused by an underlying condition, for example: osteoarthritis, rheumatoid arthritis, ulcerative colitis, endometriosis.

Controlled drugs
Medicines subject to additional legal controls due to their potential for misuse and dependence. Gabapentin and pregabalin are Class C controlled drugs and are listed in Schedule 3 of the Misuse of Drugs Regulations 2001. This affects prescribing, supply, storage and record-keeping requirements.

Dependence
A state in which a person experiences withdrawal symptoms or difficulty stopping a medicine when it is reduced or discontinued. Dependence can occur with gabapentinoids even when they are taken at prescribed doses.

Diversion
The transfer of a prescribed medicine from the intended person to another person, whether by sharing, selling or trading.

Functional improvement
Measurable improvement in what a person is able to do in daily life, such as mobility, self-care, work or social participation. In these resources, functional improvement is prioritised over pain score reduction when assessing benefit.

Gabapentinoids
A group of medicines that includes gabapentin and pregabalin. They act on calcium channels in the nervous system and are licensed for epilepsy and neuropathic pain. Pregabalin is also licensed for generalised anxiety disorder.

Misuse
Use of a medicine in a way other than prescribed, including taking higher or more frequent doses, using it for non-medical effects, or using someone else's prescription.

Neuropathic pain
Pain caused by damage to or dysfunction of the somatosensory system. The causes of neuropathic pain are complex and diverse and include diabetic neuropathy, trigeminal neuralgia, stroke, spinal cord injury, and multiple sclerosis. The pain may be constant or intermittent, and it is typically described as shooting, stabbing, burning, tingling, numb, prickling, or itching.

Older people
For the purposes of this resource, this generally refers to adults aged 65 years and over. Older people are at increased risk of adverse effects from gabapentinoids, including sedation, falls and respiratory depression.

Pacing
The practice of planning and balancing activity with rest to avoid over-exertion and symptom flare-ups. It helps people manage pain and fatigue more consistently, supporting steadier day-to-day functioning.

Palliative care
The holistic care of people with life-limiting or life-threatening condition. It aims to improve quality of life by preventing and relieving suffering by managing pain and other distressing symptoms. It may be provided to people approaching the end of life and to those with longer or uncertain prognosis and may continue for months or years.

Tolerance
A reduced response to a medicine over time, requiring a higher dose to achieve the same effect. For gabapentinoids, a perceived "wearing-off" effect more commonly reflects loss of benefit rather than true tolerance.

Validated neuropathic pain assessment tool
A structured questionnaire used to help identify whether pain is likely to be neuropathic in origin. Examples include the self-reported Leeds Assessment of Neuropathic Symptoms and Signs (sLANSS).

Withdrawal
Symptoms that may occur when a medicine is reduced or stopped, particularly if done too quickly. Gabapentinoid withdrawal symptoms can include anxiety, agitation, irritability, headache, tremor, insomnia, sweating, gastrointestinal disturbance, nausea, pain rebound and, in rare cases, seizures.

Development of resource packs

These resources have been developed with input from the All Wales Gabapentinoid Taskforce, a multidisciplinary group of pain specialists, pharmacists, clinicians, GPs, physiotherapists, and substance misuse specialists, with representation from Welsh health boards. Members of the task force include Dr Faye Graver, Christina Birkby, Dr Emma Davies, Robert Bevan, Bethan Thain, Rhian Owen, Dr Rhian Hills, Rhodri Parfitt, Tammie Ng, Dr Sunil Dasari, Dr Gemma Rogers, Simon Gill, and Ceri Clatworthy. Materials have been adapted from resources created within health boards, including collaborative work between Aneurin Bevan University Health Board (UHB) and Cwm Taf Morgannwg UHB, as well as resources from Swansea Bay UHB, Hywel Dda UHB and Betsi Cadwaladr UHB. Several of these resources were piloted in health boards prior to their inclusion. The patient pain medication review questionnaire has been adapted from the *Living Well with Pain* author's resource.

Rationale

Prescribing of gabapentinoids (gabapentin and pregabalin) has continued to increase despite the introduction of a National Prescribing Indicator (NPI) in 2017 and their reclassification as Schedule 3 controlled drugs in 2019. They are widely prescribed for a range of pain conditions, although there is very limited evidence to support their use outside neuropathic pain.

Concerns about safety and harm have also grown. In Wales, there has been a rise in deaths in which pregabalin has been recorded on the death certificate, alongside a substantial increase in gabapentinoid-related enquiries to the Welsh National Poisons Unit. Misuse and dependency have also been reported.

This growing body of evidence, together with variation in prescribing practice across Wales, highlights the need for practical resources to support the safe and appropriate use of gabapentinoids in chronic pain.

Purpose

The purpose of this resource pack is to support healthcare professionals and patients in making informed, shared decisions about the use of gabapentin and pregabalin, known as gabapentinoids, for chronic pain. These medicines should be prescribed only after a thorough clinical assessment and evaluation of potential risks, including misuse, diversion, and dependence. If treatment is started it should be reviewed regularly to ensure it remains appropriate and continues to provide benefit.

The resource materials aim to support safe and effective prescribing by providing guidance on appropriate use, balancing the potential benefits against harms, and encouraging a holistic approach to pain management. They are split into five packs providing practical tools to support prescribers in evidence-based decision making across the treatment pathway, covering background information and supporting prescribers from consideration and initiation to monitoring and deprescribing:

- Resource pack 1: Background for prescribing gabapentinoids in chronic pain
- Resource pack 2: Initiating a gabapentinoid
- Resource pack 3: Reviewing gabapentinoid use
- Resource pack 4: Reducing and stopping a gabapentinoid
- Resource pack 5: Auditing gabapentinoid prescribing and supporting tools

These resource packs can be read and used as standalone documents. While together they form a complete prescribing pathway, users may access the pack most relevant to their prescribing decision or stage of care, with Resource pack 1 providing helpful background context and Resource packs 2–5 providing practical guidance and resources through the prescribing journey. To aid navigation and readability, key messages and tools in the resource packs have been colour-coded:

Blue	Summarised information
Green	Resources and questions for patients
Red	Risks and safety points
Orange	Practical checklists

Information is also summarised in a Prescriber quick reference guide and Clinical pathway for prescribers.

Scope

These resource materials are intended for all healthcare professionals involved in the care of people with chronic pain, across both primary and secondary care settings. They are particularly relevant for those working in general practice, including GPs and pharmacists delivering structured medication reviews. They may also serve as valuable references for clinicians in specialist areas such as pain medicine, neurology, neurosurgery, rheumatology, orthopaedics, substance misuse services, and physiotherapy.

These materials apply to the prescribing, review and deprescribing of gabapentinoids for people with chronic pain that has persisted or recurred for longer than three months. This could include people receiving palliative care whose anticipated survival and clinical complexity mean that prescribing decisions should follow the same principles as for anyone else with chronic pain.

The guidance includes specific considerations for people at higher risk, including older or frail individuals, those with respiratory disease or renal impairment, a history of substance use or dependence, significant mental illness, and concurrent use of opioids, Z-drugs, benzodiazepines or other central nervous system (CNS) depressants.

These materials do not apply to people thought to be in the last months of life where the primary focus of care is comfort rather than long-term risk reduction, and do not address short-term treatment of acute or peri-operative pain. They apply only to use in chronic pain and should not be used to guide prescribing for other indications.

Prescriber quick reference guide

RED – Do NOT prescribe

Gabapentin or pregabalin should not be prescribed if any of the following apply:

- Pain is not neuropathic in origin (e.g. chronic primary pain or other unexplained chronic pain conditions) or indication is low back pain (with or without sciatica).
- A previous course did not result in meaningful functional improvement.
- There is current or past substance use, evidence of diversion, or drug-seeking behaviour.
- To replace opioids or as a way of reducing opioid use.
- The potential harms are considered to outweigh the likely benefits.

ACTION: **Do not initiate treatment. Document the decision and use alternative approaches.**

AMBER – High risk

Caution is required when prescribing gabapentin or pregabalin in the following situations:

- Co-prescribing with opioids, benzodiazepines, Z-drugs, or other CNS depressants due to an increased risk of sedation, respiratory depression and even death.
- Older adults, due to increased susceptibility to sedation, confusion and falls.
- Respiratory disease (e.g. COPD, sleep apnoea) due to an increased risk of severe exacerbations and respiratory depression.
- Renal impairment, particularly moderate to severe chronic kidney disease due to reduced renal clearance leading to drug accumulation and increased risk of toxicity if doses are not adjusted.
- Mental health conditions, particularly depression or suicidal ideation, which may increase the risk of deterioration in mental health, self-harm or suicide.

ACTION: **Avoid co-prescribing with opioids, benzodiazepines, Z-drugs, or other CNS depressants where possible. If prescribing in any of the above situations, ensure clear rationale, appropriate dosing, regular review, and risk-reduction measures.**

GREEN – May be appropriate

Prescribing could be considered appropriate if all the following criteria are met:

- Pain has been assessed as neuropathic in nature and amitriptyline or duloxetine are ineffective, not tolerated, or unsuitable.
- Shared decision-making has taken place, and the person understands both the limited likelihood of benefit and the potential harms, including the risk of dependence at prescribed doses.
- Risk assessment has been completed, with no factors identified that would make gabapentinoid prescribing inappropriate.
- No concerns have been identified regarding dependence, misuse, diversion, sedation, respiratory depression, or co-prescribing with opioids, benzodiazepines, Z-drugs or other CNS depressants.
- Prescribing is intended as a trial, and functional goals have been agreed that will be used to determine whether treatment is continued or stopped.
- A plan for review and stopping has been made and discussed with the person.

ACTION: **Prescribing may proceed as a trial with planned review.**

Clinical pathway for prescribers

Step 1: Confirm indication and place in the treatment pathway

- Confirm neuropathic pain through clinical assessment, using a validated screening tool (e.g. sLANSS). A score ≥ 12 suggests neuropathic origin.
- Record assessment findings to provide a baseline for future review.
- Do not use gabapentin or pregabalin for non-neuropathic pain (e.g. chronic primary pain), or low back pain (with or without sciatica).
- If neuropathic pain is confirmed, consider amitriptyline or duloxetine as the preferred pharmacological treatment, unless contraindicated or unsuitable.
- Consider gabapentin or pregabalin only if other first-line options are ineffective, not tolerated, or unsuitable.

Step 2: Shared decision-making and setting expectations

- Explain that medicines rarely resolve chronic pain completely and that long-term benefit is often limited.
- Explain that gabapentinoids benefit a small proportion of people, with evidence suggesting around 1 out of 9 people experience meaningful improvement.
- Discuss potential harms, including sedation, falls, cognitive impairment, misuse and dependence (which can occur at prescribed doses).
- Explain that treatment will be reviewed and stopped if benefit is not demonstrated.
- Reinforce ongoing non-pharmacological management including physical activity, physiotherapy and pacing. Consider psychological therapies such as acceptance and commitment therapy (ACT) and cognitive behavioural therapy (CBT), where available, to reduce pain-related distress and improve coping and daily functioning. Where access is limited, promote self-management.
- Encourage self-management through structured pain management programmes and recognised self-education resources (for example Live Well with Pain, Pain Concern information, the Pain Toolkit, and EPP Cymru).
- Proceed only if the person understands the limited benefit and potential risks.

Step 3: Agree functional goals (what success looks like)

- Define treatment success by improvement in function, rather than pain intensity alone, focusing on the person's ability to carry out everyday activities.
- Agree 2–3 clear, specific and measurable functional goals (e.g. ability to get around, work, do daily tasks, or sleep where this supports daytime function).
- Document the agreed measurable functional goals, describing what improvement the person should achieve (e.g., "manage personal care independently", "walk to the shop", "return to gardening twice weekly").
- Explain that continuation of treatment is dependent on achievement or maintenance of these agreed functional goals, and that treatment will be reduced and stopped if this is not demonstrated, or if harms emerge.

Step 4: Screen for safety, dependence, misuse risk

- Undertake a structured safety assessment to identify risk factors.
- Review current medicines, particularly opioids, benzodiazepines, Z-drugs, or other CNS depressants, due to the increased risk of respiratory depression and death. Reduce or stop these medicines if they are being prescribed without clear ongoing indication.

- Assess risk of misuse or non-therapeutic use (e.g. use for emotional calming).
- Consider renal function, respiratory disease, age, falls risk and mental health.
- If overall risks outweigh potential benefit, prescribing should not proceed.

Step 5: Initiate treatment as a trial

- Prescribe gabapentin in preference to pregabalin, as pregabalin is associated with a higher risk of misuse and mortality.
- Start at the lowest dose and titrate gradually, typically at weekly intervals, to minimise adverse effects and reduce harm. Adjust doses according to renal function where required.
- Allow adequate time for a therapeutic trial (up to 3 months), including titration (gabapentin up to 8 weeks; pregabalin up to 4–6 weeks) and a period at a stable dose (4 weeks).
- Aim for the lowest effective (therapeutic) dose and avoid increasing the dose unless there is clear benefit. Therapeutic doses are typically gabapentin ≥ 1,200 mg daily or pregabalin ≥ 150 mg daily, given in divided doses.
- Document a treatment management plan including starting dose, trial duration, continuation and discontinuation criteria, and review date.
- Use short initial prescriptions and do not add to repeat prescribing until functional benefit has been demonstrated.

Step 6: Review and decide whether treatment should continue

- Gabapentin and pregabalin should not be continued without review.
- Reviews may be undertaken face to face or by telephone and should occur during and after the trial period and at least annually thereafter (more frequently if risk factors change).
- Each review should assess:
  - achievement or maintenance of agreed functional goals.
  - adverse effects (e.g. sedation, cognitive impairment, falls).
  - signs of dependence, misuse, or increasing safety risk.
- Following initial trial period, if there is no improvement in function after 4 weeks at a stable dose, continued treatment is unlikely to be beneficial and the medicine should be tapered and discontinued.
- Continue treatment only if clear functional benefit outweighs harm.
- At any stage, taper and discontinue treatment if functional benefit is no longer evident or if risks outweigh benefits.

Step 7: Reduce and taper treatment when benefit is unclear or risks outweigh benefit

- Stopping gabapentin or pregabalin is appropriate when functional benefit is unclear, harms outweigh benefit, or safety risks increase.
- Reduce doses gradually (e.g. 50–100 mg pregabalin or 100–300 mg gabapentin, or approximately 10% of the total daily dose) every 1–2 weeks.
- Tailor tapering speed to the person's dose and duration of use to minimise withdrawal symptoms (e.g. anxiety, insomnia, sweating or tremor).
- Document rationale for discontinuation, dose-reduction plan and follow-up.
- If the person is reluctant to reduce treatment, explain that continuation without benefit exposes them to avoidable harm and offer additional support.
- Marked distress or difficulty adhering to dose reduction should prompt consideration of dependence and the need for closer monitoring and support.

Resource pack 1: Background for prescribing a gabapentinoid in chronic pain

Key messages – Resource pack 1: Background for prescribing a gabapentinoid in chronic pain

Deciding whether to start a gabapentinoid

- Decisions to start a gabapentinoid for pain should be made collaboratively between prescriber and the person.
- Non-pharmacological approaches should be considered first.
- Gabapentinoids should be used only where clearly indicated and after alternative medicines have been explored.
- The expected benefits, limitations, and risks should be discussed before treatment is started.
- Make the person aware that these medicines carry risks of addiction, dependence, tolerance, and withdrawal, and that anyone can become physically dependent.

Safety and risk considerations

- Gabapentinoids can cause a wide range of adverse effects, from mild to clinically significant harm.
- Risks are higher in older people, people with respiratory disease, and those taking opioids or other sedating medicines.
- Monitor closely for signs of dependence and misuse, including early refill requests, dose escalation or multiple prescribers.
- Avoid prescribing gabapentinoids to people with current or past alcohol dependence or substance use disorders.
- As gabapentinoids are classified as controlled drugs, they must be prescribed, supplied and stored in line with legal requirements.

Principles for treatment and review

- Set clear functional goals with the person before starting treatment.
- Establish a plan with the person for review and stopping at the outset, including how treatment would be reduced or stopped if it is no longer needed.
- Start treatment as a therapeutic trial, recognising that effectiveness is often limited, and review regularly to ascertain whether there is an ongoing need for continued treatment.
- If there is no meaningful benefit, taper and discontinue gradually in collaboration with the person.
- Document all assessments, discussions, decisions, and review plans clearly in the clinical record.

1.0 Background for prescribing a gabapentinoid in chronic pain

This background section provides an overview of the evidence, clinical context and key considerations relevant to the use of gabapentin and pregabalin (gabapentinoids) in the management of chronic pain. It provides a foundation for the practical guidance set out in subsequent resource packs.

1.1 Patient population

This guidance is applicable to adults who are receiving or considering gabapentinoids, with the exception of those prescribed gabapentinoids for epilepsy or generalised anxiety disorder. Where people are receiving palliative care, some aspects of the guidance may require tailoring to their individual needs (see section 1.1.1 People receiving palliative care).

1.1.1 People receiving palliative care

Palliative care may be provided to people approaching the end of life, as well as to those with longer or uncertain prognosis, and may extend over months or years. In people with longer or uncertain prognosis, pain management may involve long term prescribing.

Where gabapentinoids are prescribed for ongoing pain, people receiving palliative care will be exposed to the same risks of harm as those recognised in chronic pain prescribing, including sedation, respiratory depression, cognitive impairment, dependence and falls. These risks are increased when gabapentinoids are used alongside opioids, benzodiazepines, Z-drugs or other CNS depressants, or in the presence of frailty, renal impairment or multimorbidity.

For people receiving palliative care whose prognosis is uncertain or extended and whose symptoms are being managed over time, the principles of treatment outlined in section 1.4 should be applied in an individualised and proportionate manner, balancing potential benefit against risks. Prescribers should consider whether specialist palliative care or pain services are involved and seek advice where appropriate, particularly for complex cases or higher-risk combinations of medicines.

For people receiving end-of-life or terminal care, where the primary focus is comfort in the context of limited prognosis, the approaches described in these resources may not be appropriate.

1.2 Place in therapy

1.2.1 Licensed indications

Gabapentinoids are licensed in the UK for the management of epilepsy and neuropathic pain, with pregabalin also approved for the treatment of generalised anxiety disorder[1-5]. When used in pain management, gabapentinoids should be prescribed only where there is a clear clinical rationale and where the potential for benefit outweighs the known risks.

Neuropathic pain

Gabapentin is licensed for the treatment of peripheral neuropathic pain such as painful diabetic neuropathy and post-herpetic neuralgia in adults. Even when neuropathic pain is confirmed, only a small proportion of people experience meaningful improvement. Treatment should therefore be initiated as a therapeutic trial and continued only if there is functional improvement.

Epilepsy
While the use of gabapentinoids for epilepsy is outside the scope of these resources, it is important to note that these medicines must not be reduced or stopped abruptly when used for seizure control, as this may lead to a deterioration in seizure stability. Some people may be prescribed a gabapentinoid for neuropathic pain while also receiving other anti-seizure medicines.

Gabapentinoids contributing to seizure control

Where a person prescribed gabapentinoids for pain is identified for **dose reduction or discontinuation**, prescribers must first **confirm that the medicine is not being used for epilepsy or contributing to seizure control**.

If there is uncertainty, or if concerns arise regarding safety or interactions, advice should be sought from the person's neurologist before any changes are made.

Generalised anxiety disorder
Pregabalin is an option for generalised anxiety disorder when first-line treatments such as selective serotonin reuptake inhibitors (SSRIs) or serotonin–noradrenaline reuptake inhibitors (SNRIs) are unsuitable or ineffective[6]. Although the management of anxiety is outside the scope of this document, some people may be prescribed pregabalin for both anxiety and neuropathic pain. Where pregabalin is providing benefit for both conditions, treatment may continue provided it remains safe and effective. If pregabalin was initiated by mental health services, the original prescriber should be contacted if concerns arise regarding ongoing use, emerging harms or interactions. See section 6.0 Frequently asked questions for more information.

1.2.2 Off-label use

While gabapentinoids are often prescribed off-label for a range of clinical conditions including non-neuropathic pain syndromes, the supporting evidence for this use is limited[7-10].

Chronic primary pain

Chronic primary pain is a complex multifactorial condition for which **gabapentinoids offer minimal or no meaningful benefit**.

National Institute for Health and Care Excellence (NICE) guideline NG193 recommends that prescribers should not initiate gabapentinoids to manage chronic primary pain, as the evidence does not support their effectiveness[9]. Treatment of these conditions should focus on supported self-management, psychological approaches, physical activity, and lifestyle interventions.

Low back pain with or without sciatica

NICE guideline NG59 recommends **gabapentinoids should not be offered for low back pain, with or without sciatica**[11].

Evidence from clinical trials shows that these medicines provide no meaningful improvement in radicular leg pain compared with placebo, while adverse effects may impair mobility and participation in rehabilitation[12,13]. People who have been prescribed gabapentinoids for low back pain with or without sciatica should be reviewed and gradual discontinuation should be encouraged, with ongoing support

and access to appropriate non-pharmacological services. See section 6.0 Frequently asked questions for more information.

Do not use gabapentinoids to replace opioids

Gabapentinoids **should not be used to replace opioids** or as a way of reducing opioid use, as the evidence does not support this practice.

Summary: When gabapentinoids should and should not be used

Use gabapentinoids only when:

- There is a clear diagnosis of neuropathic pain.
- Alternative pharmacological options (e.g. amitriptyline and duloxetine) have been tried and were ineffective, not tolerated, contraindicated, or unsuitable.
- Shared decision-making has taken place and goals are agreed.

Do NOT use gabapentinoids when:

- The indication is low back pain with or without sciatica.
- Pain is non-neuropathic or unexplained.
- The person is at high risk of misuse, diversion or sedation-related harm.

Key message:
Gabapentinoids have limited efficacy and should only be initiated when benefits clearly outweigh risks.

1.3 Risks

Gabapentinoids are associated with a range of risks that must be considered before initiation and throughout treatment. These include common adverse effects that may affect day-to-day functioning, as well as more serious harms such as respiratory depression, dependence and misuse. The Medicines and Healthcare products Regulatory Agency (MHRA) has issued multiple Drug Safety Updates highlighting reports of severe respiratory depression, in some cases without concomitant opioids use[14-17].

1.3.1 Adverse effects

Gabapentinoids are associated with a range of adverse effects. While it is not practical to discuss every possible adverse effect during an initial consultation, it is important to highlight those that are common, clinically significant or likely to affect safety and quality of life.

Common adverse effects include drowsiness, dizziness, fatigue, weight gain or increased appetite, and changes in mood or behaviour. Some of these adverse effects may impair balance, concentration, driving ability and ability to carry out daily activities. Other important effects include erectile dysfunction and cognitive problems which can impact quality of life and treatment adherence.

Severe respiratory depression

Gabapentinoids are associated with **a rare risk of severe respiratory depression even without concomitant opioid medicines**.

Older people and people with compromised respiratory function (e.g. chronic obstructive pulmonary disease (COPD), respiratory or neurological disease, or renal impairment at higher risk of experiencing severe respiratory depression.

Table 1 summarises the key adverse effects, grouped by how frequently they occur according to the Summary of Product Characteristics (SmPC)[4,5]. Some people may experience no side effects at all, while others may notice several occurring together, especially when treatment is first started or when doses are increased. The table can be used as a guide for discussion, helping to explain which effects are more likely and which are less common.

Table 1. Adverse effects associated with gabapentin and pregabalin

(SmPC frequency categories indicate the following numeric ranges: Very common ≥ 10%, Common 1–< 10%, Uncommon 0.1–< 1%, Rare 0.01–< 0.1%)

Adverse effect	Gabapentin	Pregabalin	Clinical relevance
Dizziness, somnolence	Very common	Very common	Contributes to sedation, impaired driving and falls
Ataxia (unsteadiness)	Very common	Common	Risk of falls due to poor balance
Fatigue	Very common	Common	May affect daily functioning
Headache	Common	Very common	May limit tolerability
Euphoria *(feeling unusually "high")*	Not a recognised common effect	Common	Recognised with pregabalin. May produce a sense of wellbeing or "high", which can contribute to misuse or non-medical use in some patients
Cognitive effects (confusion, memory impairment/amnesia)	Common	Common	May impair concentration, memory and daily functioning
Gastrointestinal effects *(nausea, vomiting, constipation, diarrhoea, flatulence, dry mouth)*	Common	Common	Usually mild but may affect adherence
Weight gain/increased appetite	Common	Common	Relevant with longer-term use (metabolic impact, adherence)

Table 1. Adverse effects associated with gabapentin and pregabalin (continued)

Adverse effect	Gabapentin	Pregabalin	Clinical relevance
Visual disturbance *(blurred vision, diplopia)*	Common	Common	May contribute to falls and affect driving
Mood and behavioural changes	Common (emotional lability)	Common (irritability)	Can affect adherence and signal psychiatric adverse effects
Tremor	Common	Common	May affect fine motor tasks (e.g. writing)
Peripheral oedema	Common	Common	Can worsen heart failure or cause discomfort
Erectile dysfunction/ impotence	Common	Common	May affect quality of life and adherence
Suicidal ideation/ behaviour	Not known	Rare	Low frequency but serious class effect; important safety consideration
Respiratory depression	Rare	Not known	Uncommon but serious; risk increases with opioids and other sedatives

1.3.2 Populations at increased risk of adverse effects

Certain groups are at increased risk of significant harm from gabapentinoids and therefore require caution when these medicines are prescribed. These include older people, people taking opioids or other sedating medicines and those with respiratory disease. For more details see Table 2.

Table 2. Populations at increased risk of adverse effects with gabapentinoids

Older people
• More vulnerable to the sedative and cognitive effects of gabapentinoids. • Age-related physiological changes increase the likelihood of confusion, memory disturbance, impaired coordination, falls and functional decline[4,5,18]. • Cognitive symptoms often improve when gabapentinoids or other CNS depressants are reduced or discontinued. • Risk of respiratory depression increases, particularly at higher doses or when gabapentinoids are used alongside other sedating medicines[16].
People using other CNS depressants
• Co-prescribing gabapentinoids with opioids, benzodiazepines, Z-drugs, or other CNS depressants should be avoided where possible, as it substantially increases the risk of sedation, respiratory compromise, toxicity and confusion[16]. • If co-prescribing cannot be avoided, these people require close monitoring, and dose adjustments should be considered, particularly where renal function is reduced.

Table 2. Populations at increased risk of adverse effects with gabapentinoids (continued)

People with respiratory problems
• People with existing respiratory conditions, such as COPD or sleep apnoea, are at increased risk of severe exacerbations or respiratory depression when taking gabapentinoids[15]. • Risk is further increased if gabapentinoids are used in combination with opioids or other sedating medicines[15]. • Prescribers should start at low doses, avoid unnecessary co-prescribing of opioids or other CNS depressants and ensure appropriate monitoring.
People with mental health conditions
• Increased risk of worsening mental health, self-harm, suicide, or misuse in those with depression, suicidal ideation or behaviour, or substance use. • Gabapentinoids may worsen mood symptoms in some people and may cause emotional blunting, reduced motivation or behavioural disinhibition[19]. • Before prescribing, screen for depression and suicidal risk. • Avoid initiating in people with known or suspected substance use disorders[20]. • Where concerns are identified, seek advice from mental health services to support decision-making.
People with renal impairment
• Gabapentin and pregabalin are eliminated unchanged by the kidneys. Reduced renal function increases the risk of accumulation and toxicity (e.g. sedation, dizziness, confusion or respiratory depression). • According to the SmPCs, dose adjustment should be guided by creatinine clearance (CrCl) calculated using the Cockcroft–Gault equation[4,5], and therefore CrCl is used throughout this document when referring to renal dosing. However, in clinical practice, estimated glomerular filtration rate (eGFR) can be used when the information needed to calculate CrCl is not available. • Renal function should be assessed before initiation and monitored at least annually. • Monitoring should be undertaken more frequently if renal function declines or if clinical circumstances indicate an increased risk of drug accumulation, with the frequency determined by clinical judgement. See section 6.0 Frequently asked questions for more information.
Pregnant and breastfeeding people
• The MHRA has warned of a possible increased risk of congenital malformations with pregabalin use during pregnancy and recommends effective contraception for women of childbearing potential[21]. • For gabapentin, the SmPC advises that it should be used during pregnancy only if the potential benefit outweighs the risk to the foetus. Routine contraception is not specifically recommended; however, pregnancy planning and potential risks should be discussed with people of childbearing potential[2,4,5]. • Both gabapentin and pregabalin are excreted into breast milk. Use during breastfeeding should be considered on an individual basis, taking into account the potential risks to the infant and the clinical need for treatment[1-5]. If treatment is required, the lowest effective dose should be used, and the infant should be monitored for adverse effects such as sedation or poor feeding.

Summary: Who is at highest risk of harm?

People at greatest risk of significant adverse effects include:

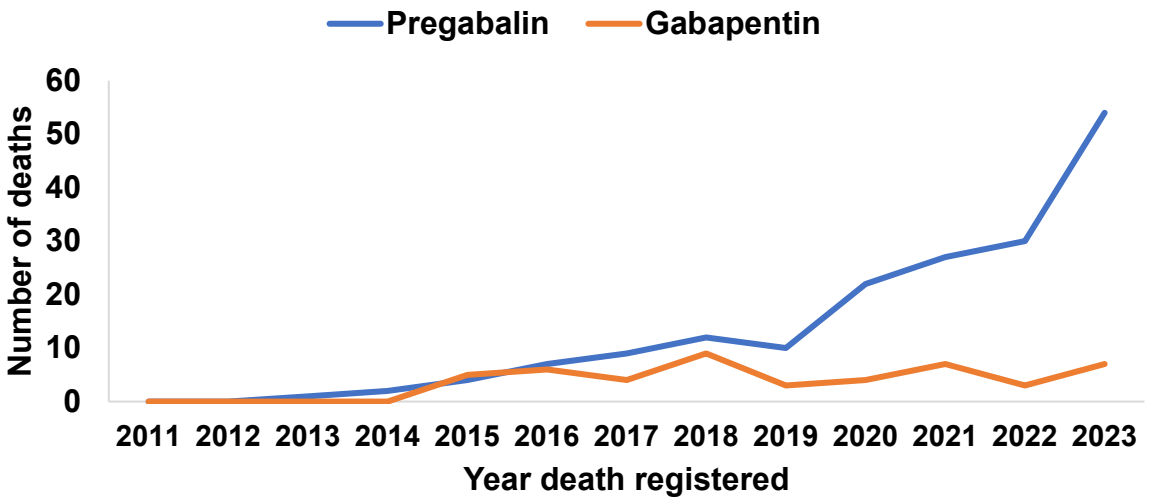
- **Older people**: increased susceptibility to sedation, confusion, falls and respiratory depression.
- People with **respiratory disease** (such as COPD): increased risk of severe exacerbations and respiratory depression.
- People taking **CNS depressants** such as opioids, benzodiazepines, Z-drugs or alcohol.
- People with **renal impairment**: risk of accumulation and toxicity without dose adjustment.
- People with **mental health conditions** or **substance use disorders**: higher risk of misuse, disinhibition or worsening mood symptoms.

Clinical action: Use the lowest effective dose, review regularly, and avoid unnecessary co-prescribing of opioids, benzodiazepines, Z-drugs or other CNS depressants.

1.3.3 Mortality risk

Gabapentinoids contribute to drug-related deaths, particularly when used in combination with other CNS depressants such as opioids, benzodiazepines, Z-drugs or alcohol[22]. In Wales, there has been a concerning rise in the number of deaths in which pregabalin was mentioned on the death certificate, increasing from 10 deaths in 2019 to 54 deaths in 2023[23] (see Figure 1), highlighting the need for careful, responsible prescribing. Further concern is reflected in data from the Welsh National Poisons Unit (Wales data from 2015–2024, all ages), which show a notable rise in gabapentinoid-related poisoning queries over the past two years. This increase adds to the growing evidence of safety risks associated with these medicines.

Figure 1. Number of deaths in Wales for which gabapentin and/or pregabalin was mentioned on the death certificate[8]



1.3.4 Dependence

Dependence on gabapentin or pregabalin can occur when these medicines are taken at therapeutic doses[4,5].

Presentation of dependence

Dependence may present as **difficulty reducing the dose**, requests for **early repeats** or **taking more than prescribed**.

A perceived reduction in effect over time is commonly reported and usually indicates that the medicine is no longer providing benefit. In this situation, increasing the dose is unlikely to be helpful and may increase the risk of harm. All people prescribed gabapentinoids should be considered at risk of dependence, and treatment should be reviewed regularly to ensure that benefits continue to outweigh potential harms.

MHRA Drug Safety Update (January 2026)

The MHRA issued a Drug Safety Update, Improving Information Supplied with Gabapentinoids (Pregabalin/Gabapentin), Benzodiazepines and Z-Drugs, highlighting the risks of addiction, dependence, tolerance and withdrawal, associated with these medicines. MHRA advised prescribers should:

- Provide clear information about the risks of addiction, dependence, tolerance and withdrawal, communicated using non-judgemental language
- Explain that withdrawal symptoms may occur following dose reduction or discontinuation
- Advise the person not to stop treatment abruptly and to seek medical advice before doing so
- Provide the MHRA gabapentinoid patient leaflet on the risks of addiction, dependence and withdrawal
- Report suspected adverse reactions including dependence or withdrawal via the Yellow Card scheme.

1.3.5 Misuse

Gabapentinoids, particularly pregabalin, have recognised misuse potential. Misuse and dependence have been reported in the SmPCs and caution is advised when prescribing to individuals with a history of substance use[2,4,5,24-26].

Misuse is considered to be uncommon in the general population[27,28] but is more prevalent among individuals who misuse opioids[28]. There is also evidence of increasing availability through illicit supply, including online sources[29], and higher rates of misuse have been reported within substance use services and among individuals in prison and following release[30].

Misuse in pregabalin versus gabapentin

Pregabalin is **misused more frequently** than gabapentin, likely reflecting differences in pharmacokinetic profile.

The rapid absorption, faster onset of action, greater potency, and near-linear dose response curve of pregabalin can produce more intense psychoactive effects at higher doses than gabapentin[31,32]. Reported desired effects of pregabalin include euphoria, relaxation, enhanced sociability and a sense of calm[31]. These effects are

typically achieved with non-therapeutic use, with reported single doses ranging from 200 mg to 5 g[31]. By contrast gabapentin demonstrates a plateau in its dose response effect at higher doses (around 2,400–3,600 mg), which may limit further psychoactive effect with dose escalation.

Prescribers should remain alert to behaviours indicative of misuse or diversion, including stockpiling or use of doses exceeding those prescribed for psychoactive effect.

Potential red flags for misuse or dependence

- Long-term **off-label prescribing** with refusal to consider alternatives.
- **Difficulty reducing** or **stopping** use due to withdrawal symptoms.
- History of psychiatric illness, trauma, or substance use.
- Specific requests to initiate treatment, particularly post-prison.
- Frequent early prescription requests or reports of lost medication.
- Escalating dosage requests or use beyond prescribed amounts.
- Seeking prescriptions from **out-of-hours** services.
- **Concerns raised** by professionals, carers, or family.
- **Hostile behaviour** when prescriptions are delayed or withheld.
- **Non-attendance** at review or follow-up appointments.
- **Refusal to engage** with drug screening or specialist addiction services.
- Attempts to obtain medication from **multiple prescribers**, including locums.
- Procuring gabapentinoids from the **internet** or **informal sources**.
- **Sedated presentation** during appointments.
- **Decline** in work, home, or social functioning.
- Evidence or suspicion of **injecting or nasal inhalation** of the medication.
- Experiencing withdrawal effects when the medicines are stopped suddenly.
- Expression of **cravings**, even if it is causing adverse effects.

1.3.5.1 Referral and support

If misuse is suspected, people should be referred to the most appropriate local service for assessment and support. In many areas, substance use services accept referrals only where there is clear evidence of misuse or illicit acquisition. In some health boards, dedicated services support people using prescribed medicines who require structured reduction, and some primary care teams provide this support directly. Where these services are unavailable, management should follow local policies, with specialist advice sought where appropriate.

Summary: Dependence and misuse of gabapentinoids

Gabapentinoids carry a recognised risk of dependence, misuse and diversion, even when taken as prescribed.

Dependence

- Anyone prescribed gabapentin or pregabalin may develop dependence.
- Withdrawal symptoms can include anxiety, agitation, irritability, headache, tremor, insomnia, sweating, gastrointestinal disturbance, nausea, pain rebound and, in rare cases, seizures.

- A “wearing-off” effect usually indicates loss of benefit, increasing the dose rarely helps and may cause harm.
- Difficulty reducing or stopping should always prompt review and shared decision-making.

Misuse and diversion

- Misuse is more common with pregabalin due to its faster onset and greater psychoactive effects.
- High-risk groups include people with current or past alcohol dependence or substance use, people recently released from prison, and people using opioids, benzodiazepines, Z-drugs or other CNS depressants.
- An illicit market exists; some people may attempt to obtain gabapentinoids from multiple prescribers or online sources.

All people taking gabapentinoids should be monitored for signs of misuse and supported through regular review.

1.3.6 Legal status

1.3.6.1 Controlled drugs

Gabapentin and pregabalin are classified as Class C controlled drugs and placed in Schedule 3 of the Misuse of Drugs Regulations 2001 because of their potential for misuse and dependence[14]. This classification imposes specific requirements regarding prescribing, supply, record-keeping and storage. Prescribers must ensure that prescriptions meet the legal requirements for controlled drugs.

1.3.6.2 Driving

People prescribed gabapentinoids should be informed about the possible effects of these medicines on their ability to drive or operate machinery[33]. They must not drive if their performance is impaired by medication or if they are using doses other than those prescribed[34,35]. Individuals in occupations that involve operating machinery should carefully assess whether sedation, dizziness, or reduced concentration might compromise their own or others’ safety[33,35]. Prescribers must follow relevant Driver and Vehicle Licensing Agency (DVLA) guidance, provide suitable advice, and document the discussion[35].

1.4 Principles of treatment

The decision to prescribe a gabapentinoid should be made in accordance with the principles of treatment outlined here and addressed in more detail in the relevant sections.

Principles of treatment comprise:

- **Appropriate indication:** Prescribe only when there is a clear clinical rationale, such as confirmed neuropathic pain (see section 2.1).
- **Non-pharmacological approaches:** Explore non-pharmacological options before considering gabapentinoids, as these do not carry the risks associated with medicines (see section 2.2.1).
- **Alternative pharmacological options:** Consider alternative medicines, particularly those with safer profiles or stronger evidence base for the person's condition (see section 2.2.3).
- **Shared decision making:** Prescribing should follow a shared decision-making process, ensuring the person understands the potential benefits, limitations and risks of treatment (see section 2.3).
- **Setting goals:** Agree realistic, measurable treatment goals prior to initiation, focusing on improvement in function rather than complete pain relief (see section 2.4).
- **Safe prescribing considerations:** Apply safe prescribing principles, including assessment of risk factors for harm, dependence and misuse (see section 2.5).
- **Therapeutic trial:** Initiate as a therapeutic trial with a clear plan for dose titration, an agreed period for assessing benefit, and a scheduled review to determine whether continuation is appropriate (see section 2.7).
- **Reviews:** Review treatment regularly to assess effectiveness, safety and adherence. Early review should assess pain, function and tolerability. Longer-term reviews should occur every six to twelve months (see Resource pack 3).
- **Discontinuation:** Discontinue treatment if treatment goals are not met or harms outweigh benefits. Dose reduction should be gradual, with appropriate support and continuation of non-pharmacological strategies (see Resource pack 4).
- **Documentation:** Document all decisions in person's clinical record, including at initiation (see section 2.8), during review (see section 3.7) and when discontinuing (see section 4.10).

Appendix 1a: Information poster for prescribers provides a summary of these principles for display.

Appendix 1a: Information poster for prescribers – Gabapentin and pregabalin

Resource pack 2: Initiating a gabapentinoid

Key messages – Resource pack 2: Initiating a gabapentinoid

DO

- Confirm neuropathic pain using a validated assessment tool (e.g. sLANSS).
- Explore non-pharmacological approaches before prescribing gabapentinoids.
- Consider amitriptyline or duloxetine as the preferred treatment options, unless contraindicated or not tolerated, due to a stronger evidence base and more favourable NNT values for neuropathic pain.
- Set realistic expectations, explaining that gabapentinoids provide moderate benefit for only a small proportion of people and are unlikely to eliminate pain completely.
- Agree measurable functional goals before starting treatment and use these goals to judge benefit during review.
- Discuss potential risks and adverse effects, including sedation, cognitive impairment, falls, dependence, withdrawal symptoms and the increased risk of respiratory depression, particularly when used alongside opioids.

DON'T

- Do not consider gabapentinoids for low back pain with or without sciatica.
- Do not consider gabapentinoids if amitriptyline or duloxetine have not yet been trialled, unless the person cannot tolerate or has clear contraindications to these options.
- Do not consider gabapentinoids for non-neuropathic pain, including chronic primary pain or other unexplained chronic pain conditions, as they are unlikely to provide benefit.
- Do not consider gabapentinoids where opioids or other CNS depressants are currently being prescribed unless unavoidable and closely monitored, due to the increased risk of respiratory depression.

Summary guide – Resource pack 2: Initiating a gabapentinoid

1. Initiation assessment

- Confirm indication with clinical assessment or validated tool.
- Assess renal function: adjust dose if required according to CrCl.
- Screen for mental health conditions.
- Consider and address substance use risks.
- Consider frailty, falls risk, and cognitive impairment.
- Consider and address opioid, benzodiazepine, Z-drug or other CNS depressant use.
- Advise on driving and safety-critical work and follow DVLA guidance.
- Discuss risks in pregnancy and confirm effective contraception where relevant.

2. Shared decision-making and consent

- Explain that ~one in nine people achieve meaningful improvement.
- Set realistic expectations: aim is improved function not complete pain relief.
- Discuss potential adverse effects and risk of dependence and withdrawal.
- Counsel on controlled drug responsibilities.
- Agree measurable treatment goals.
- Provide written patient information and document informed consent in records.

3. Choice of medicine

- If a gabapentinoid is considered appropriate, gabapentin should be tried first. If it is contraindicated, not tolerated, or unsuitable (e.g. due to renal function or other factors), pregabalin may be considered.

4. Therapeutic trial and dosing

- A therapeutic trial should be undertaken.
- Treatment should be discontinued if there is no clear evidence of functional improvement or if harms outweigh benefits.

5. Renal impairment

- Always adjust doses in renal impairment and frailty and review regularly.

6. Monitoring and safety

- Review during dose titration and again after 4–6 weeks on a stable dose to assess the outcome of the trial.
- Assess pain relief, functional improvement, mood, and adverse effects.
- Actively enquire about misuse, dependence, and diversion, especially in people at higher risk. When co-prescribed with opioids, reinforce risks and consider reducing sedative burden.

7. Prescribing and supply rules

- Do not issue as a repeat prescription until treatment efficacy is confirmed.
- If effective: add to repeat prescribing system with a clear review date noted.
- If ineffective: taper gradually and discontinue.
- Avoid prescribing to people at risk of misuse or diversion; if prescribed, use short prescription durations.

8. Documentation

- Record indication, assessment findings, and rationale for initiation.
- Document chosen agent, initial dose, titration plan, and intended trial duration.
- Record agreed treatment goals and criteria for continuation or discontinuation.
- Document safety counselling, particularly around opioids and controlled drugs.
- Record review plan, monitoring schedule, and patient information provided.

2.0 Initiating a gabapentinoid

Medicines for neuropathic pain are often of limited effectiveness and benefit only a small proportion of people. Decisions to prescribe should be based on shared decision making following thorough clinical assessment, risk evaluation and patient education.

2.1 Identifying neuropathic pain

When considering gabapentinoid treatment, prescribers should assess whether the person's pain is likely to be neuropathic in origin using a validated screening tool, such as the sLANSS. A score of 12 or higher suggests neuropathic pain. Assessment findings should be documented to provide a baseline for evaluating treatment response and informing future clinical decisions.

2.2 Exploring alternative treatment options before gabapentinoids

Where a diagnosis of neuropathic pain is identified, consideration should first be given to non-pharmacological and pharmacological alternatives. Non-pharmacological approaches should be continued alongside any medication.

2.2.1 Non-pharmacological approaches

This includes promoting physical activity, physiotherapy and pacing. Psychological therapies such as ACT and CBT should be considered, where available, to reduce pain-related distress and improve coping and daily functioning. Where access to services is limited, self-management approaches should be encouraged.

Live Well with Pain has produced Ten footsteps to living well with pain, which provides guidance on self-care and can be used to encourage engagement in non-medical management[36]. Other recognised self-education resources include Pain Concern information, the Pain Toolkit, and EPP Cymru). Appendix 2a: GP waiting room poster provides a summary of some of these approaches for patients. Section 7.0 Useful resources also provides a range of patient resources to support self-management.

2.2.2 Social prescribing in chronic pain management:

Where services are available, social prescribing should be considered as an approach to refer people to non-medical, community-based support to improve physical, emotional and social wellbeing. For people living with persistent pain, it may support coping, reduce distress and improve quality of life.

In the context of gabapentinoid prescribing, social prescribing is particularly valuable because it may:

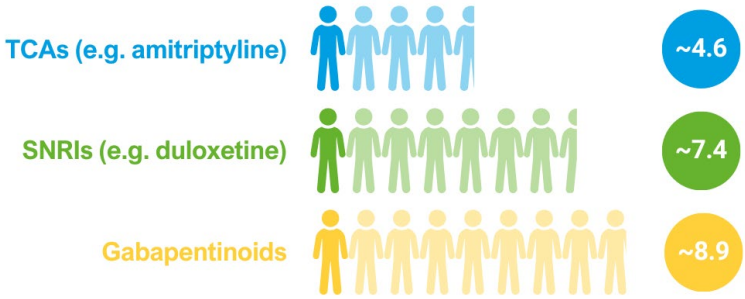
- Support self-management and functional improvement, and reduce reliance on long-term analgesics.
- Complement physiotherapy and pain-management programmes by addressing social, emotional and lifestyle factors.
- Support people who may be struggling with low mood, fear of movement, poor sleep or limited social engagement, all of which may exacerbate pain.
- Prepare people for dose reduction by increasing confidence in non-pharmacological strategies.

2.2.3 Alternative pharmacological treatments

Before prescribing a gabapentinoid, alternative pharmacological options such as amitriptyline and duloxetine should be considered for neuropathic pain unless contraindicated, ineffective or not tolerated.

NICE clinical guideline CG173: Neuropathic pain in adults and the All Wales Medicines Strategy Group (AWMSG) Pharmacological management of pain guidance recommends amitriptyline, duloxetine, gabapentin, or pregabalin as treatment options for neuropathic pain[37]. Figure 2 summarises approximate numbers needed to treat (NNT) from a 2025 systematic review and meta-analysis[38]. NNT represents the average number of people who need to be treated for one person to achieve meaningful reduction in pain (defined as at least 50% or 30% reduction in baseline pain intensity or moderate pain relief). As shown in the figure, tricyclic antidepressants (TCAs) (e.g. amitriptyline) and SNRIs (e.g. duloxetine) generally have lower NNTs than gabapentinoids, indicating a greater likelihood of benefit. For gabapentinoids, approximately 1 in 9 people achieve meaningful pain relief.

Figure 2. NNT for commonly used medicines for neuropathic pain[38]



2.3 Shared decision making

Gabapentinoid prescribing should always follow a shared decision-making process. Discussions should cover the potential benefits and limitations of the medicine, the known risks, alternative approaches and the person's preferences and goals. Prescribers should also explore biopsychosocial factors that contribute to the person's pain experience. The Living with Persistent Pain in Wales guidance may support broader discussions around self-management and functional goals where appropriate[39].

Discussions should also include a clear explanation that gabapentinoid treatment is initiated as a therapeutic trial, with response reviewed and treatment discontinued if meaningful benefit is not achieved. Clear expectations should be established at the outset. Only a small proportion of people, approximately 1 in 9, experience meaningful pain relief [40-42]. Treatment should therefore be framed as aiming to improve function rather than eliminate pain. Complete pain relief is rarely achievable, and unrealistic expectations can contribute to inappropriate long-term prescribing.

Appendix 2b: Structured consultation when considering gabapentinoids provides a framework to support these conversations. People should also be offered Appendix 2c: Patient information leaflet – Gabapentin or pregabalin for pain to support understanding of how the medicines work, their potential risks, and alternative options.

2.4 Setting functional goals

Before treatment begins, the prescriber and person should agree on realistic functional goals, that is, measurable improvements that focus on improving daily functioning rather than eliminating or reducing pain intensity alone. Goals may include enhanced mobility, better participation in daily activities, increased ability to work or improved social participation. These goals should form the basis of later reviews and decisions about continuation or discontinuation.

2.5 Safety considerations before prescribing

Gabapentinoids are associated with a range of risks that must be considered before initiation and throughout treatment. These include common adverse effects that may affect day-to-day functioning, as well as more serious harms such as respiratory depression, dependence and misuse.

2.5.2 Pre-prescribing safety assessment

When a decision has been reached to proceed to a trial of treatment, a pre-prescribing safety assessment should be completed and documented. This assessment should consider factors that may increase the risk of harm or influence suitability, dosing or monitoring (see Table 3). Appendix 2d: Medicine initiation template may be used to support structured assessment and documentation.

Cautions in prescribing

Avoid co-prescribing gabapentin or pregabalin with **other CNS depressants** wherever possible, particularly **benzodiazepines, Z-drugs, and opioids**.

Both gabapentin and pregabalin can cause **unsteadiness** and should be used **with caution in people at risk of falls**.

Warn people before prescribing gabapentin or pregabalin **that dependence can occur at prescribed doses** and that **withdrawal symptoms may be significant** on dose reduction or stopping.

Monitor for dependence, misuse, and diversion throughout treatment.

Table 3. Pre-initiation safety check for gabapentinoids

Safety check	Why it matters	Actions to take
Renal function (CrCl)	Gabapentinoids are renally excreted; impaired function increases risk of accumulation, toxicity and adverse effects.	Calculate CrCl before initiation. Adjust dose accordingly. Refer to renal dosing guidance (see section 2.7.1).
Mental health status	These medicines can worsen low mood or suicidal ideation, especially in vulnerable people.	Screen for depression, suicidal thoughts or behaviour. Avoid prescribing if there is active risk. Liaise with mental health services if needed.
Substance use/misuse risk	Increased risk of dependence, misuse and diversion (greater with pregabalin).	If there is a history of alcohol dependence, prescription medicine misuse, or substance use, avoid prescribing. Where treatment is considered essential, safeguards must be in place (e.g. limited supply intervals, regular review, and pharmacy support).
Cognitive impairment or falls risk	Increased risk of dizziness, sedation, confusion and impaired coordination, leading to falls.	Review polypharmacy (particularly CNS depressants and anticholinergics). Start at lower doses and titrate slowly.
Concomitant opioid use	Increases risk of sedation, respiratory depression, and overdose even at standard doses.	Avoid co-prescribing where possible. Consider opioid reduction. Counsel on risks and monitor closely if unavoidable.
Other CNS depressants/ alcohol	May cause additive CNS depression when used with gabapentinoids.	Review medicines (e.g. benzodiazepines, Z-drugs) and alcohol use. Reduce where possible and counsel on risks.
Respiratory disease	Risk of severe respiratory depression, including without opioids. Higher risk in conditions such as COPD.	Exercise caution. Start at low dose and monitor closely. Avoid co-prescribing opioids and other CNS depressants where possible.
Older people/ frailty	Greater susceptibility to adverse effects (e.g. sedation, cognitive impairment and falls).	Use lower doses and slower titration. Monitor closely.
Driving/ operating machinery	May impair alertness, reaction times and concentration.	Provide advice regarding drowsiness and impaired performance. Follow DVLA guidance; do not drive if affected.
Pregnancy/ contraception	Limited safety data; pregabalin associated with increased risk of congenital malformations.	Where applicable, check pregnancy status. If the person is of childbearing potential, confirm contraception is in place and discuss risks if planning pregnancy.

2.6 Choice of gabapentinoid

Gabapentin and pregabalin are structurally similar medicines acting through the alpha-2-delta subunit of voltage-gated calcium channels. Bioavailability of gabapentin decreases as the dose increases whereas pregabalin bioavailability is largely independent of dose, which explains the increased risk associated with high dose pregabalin use.

There are no head-to-head trials directly comparing the efficacy of gabapentin and pregabalin. Evidence suggests similar effectiveness, based on comparable NNTs. Gabapentin is generally preferred because pregabalin is associated with a higher risk of misuse, dependence, withdrawal and respiratory depression, and has greater psychoactive effects.

Misuse potential of pregabalin

Pregabalin has a **higher misuse potential**, is frequently sought by people with **substance use** risk or **alcohol dependence** and has a recognised high **street value**. Prescribing should be **avoided** in these circumstances.

2.7 Gabapentinoid trial, dosing and titration

Initiate treatment as a therapeutic trial with agreed functional outcomes to assess response (e.g. ability to perform daily tasks, or engagement in physical activity), with a planned review date and an exit plan outlining how treatment will be reduced and stopped if no functional benefit is demonstrated.

In people receiving palliative care, specialist services may use a different titration schedule to reflect clinical complexity or symptom burden; where this occurs, the agreed plan should be clearly documented and include how functional benefit and harms will be reviewed after the trial period.

Gabapentinoid prescribing and titration

- Start at a low dose and titrate gradually. Although the British National Formulary (BNF) includes daily dose increases, weekly titration is preferred in primary care to reduce adverse effects, minimise harm and unnecessary dose escalation (see **Tables 4** and **6** for dose titration examples).
- Allow adequate time for a therapeutic trial:
  - Gabapentin can take up to 8 weeks for dose titration, followed by 4 weeks at a stable dose.
  - Pregabalin can take up to 4–6 weeks for dose titration, followed by 4 weeks at a stable dose.
- Therapeutic effect is usually observed at doses of:
  - Gabapentin ≥ 1,200 mg daily (in divided doses).
  - Pregabalin ≥ 150 mg daily (in divided doses)[43,44].
- **Maintain the lowest dose that demonstrates improvement in pain and function**; there is no requirement to continue titration to the highest stated dose.
- Higher doses (gabapentin above or equal to 600 mg three times daily or pregabalin above or equal to 150 mg twice daily) should only be considered following review and where some benefit has already been demonstrated.

- **Slower titration** should be considered in older people, people with frailty, people known to be susceptible to adverse effects, and people with polypharmacy or renal impairment (see **Tables 5** and **7** for adjusted titration examples).
- If not tolerated or no therapeutic response is observed after 4–6 weeks at a stable dose, discontinue treatment gradually over a minimum of 1 week[8].
- Continue treatment only where benefit is demonstrated against agreed functional goals, using the lowest effective dose.

Table 4. Recommended titration schedule for gabapentin

Week	Morning dose	Midday dose	Evening dose
1	None	None	300 mg
2	300 mg	None	300 mg
3	300 mg	300 mg	300 mg
4	300 mg	300 mg	600 mg
5	600 mg	600 mg	600 mg

Gabapentin – After week 4:
Consider maintaining treatment at a stable therapeutic dose (≥ 1,200 mg daily in divided doses) for four weeks, with a review at the end of this trial period before any further dose increases are made. Doses above or equal to 600 mg three times daily should only be considered following review and where some benefit has already been demonstrated.

Table 5. Slow titration for gabapentin *(e.g. older people, frailty, known susceptibility to adverse effects, polypharmacy, renal impairment)*

Week	Morning dose	Midday dose	Evening dose
1	None	None	100 mg
2	100 mg	None	100 mg
3	100 mg	100 mg	100 mg
4	100 mg	100 mg	200 mg
5	200 mg	100 mg	200 mg
6	200 mg	200 mg	200 mg
7	200 mg	200 mg	300 mg
8	300 mg	200 mg	300 mg
9	300 mg	300 mg	300 mg

Table 6. Recommended titration schedule for pregabalin *(for use where gabapentin is not appropriate or unsuitable)*

Week	Morning dose	Evening dose
1	None	75 mg
2	75 mg	75 mg
3	75 mg	150 mg
4	150 mg	150 mg

Pregabalin – After week 2:
Consider maintaining treatment at a stable therapeutic dose (≥ 150 mg daily in divided doses) for four weeks, with a review at the end of this trial period before any further dose increases are made. Doses above or equal to 150 mg twice daily should only be considered following review and where some benefit has already been demonstrated.

Table 7. Slow titration for pregabalin (e.g. older people, frailty, known susceptibility to adverse effects, polypharmacy, renal impairment)

Week	Morning dose	Evening dose
1	None	25 mg
2	25 mg	25 mg
3	25 mg	50 mg
4	50 mg	50 mg
5	50 mg	75 mg
6	75 mg	75 mg

Adding a gabapentinoid to repeat medications

Do NOT add a gabapentinoid to repeat medications during initial trial.
If effective after trial period → add to repeat with clear review date.
If ineffective → taper dose, issue acute supply only.

2.7.1 Dose adjustment in renal impairment

Gabapentin and pregabalin require dose adjustments in renal impairment because reduced clearance increases the risk of toxicity and adverse effects (see Tables 8 and 9).

Creatinine clearance (CrCl) should be used where available to assess renal function and determine appropriate dosing. Where this is not recorded, estimated glomerular filtration rate (eGFR) can be used where appropriate, in line with BNF guidance. For people on haemodialysis, seek specialist advice.

Table 8. Renal dose adjustments for gabapentin

CrCl (ml/minute)	Total daily gabapentin dose (administered in three divided doses)	Notes
50–79	600–1,800 mg	Total daily dose administered in three divided doses.
30–49	300–900 mg	Total daily dose administered in three divided doses.
15–29	150–600 mg	150 mg daily dose to be given as 300 mg in three divided doses (100 mg three times daily) on alternate days.
< 15	150–300 mg	150 mg daily dose to be given as 300 mg in three divided doses (100 mg three times daily) on alternate days. For people with CrCl < 15 ml/min, the daily dose should be reduced in proportion to CrCl (e.g. people with a CrCl of 7.5 ml/min should receive half the daily dose that people with a CrCl of 15 ml/min receive).

Table 9. Renal dose adjustments for pregabalin

CrCl (ml/minute)	Total daily pregabalin dose	Notes
≥ 30– < 60	75–300 mg	Total daily dose administered in two or three divided doses.
≥ 15– < 30	25–150 mg	Total daily dose administered in one or two divided doses.
< 15	25–75 mg	Total daily dose administered once daily.

Appendix 2c: Patient information leaflet – Gabapentin or pregabalin for pain and Appendix 2e: Patient trial plan help document treatment goals, dosing schedules, and review plans supporting a personalised and structured approach to care.

2.8 Treatment management plan and documentation

Before issuing the first prescription, a clear treatment plan should also be agreed and documented with the person. Appendix 2f: Treatment agreement plan – Gabapentin or pregabalin can be used to establish shared understanding of the rationale for treatment, the potential benefits and limitations, and the expectations for review and monitoring.

Treatment plan requirements

The **treatment plan** should **confirm that the person**:

- understands the expected benefit and limitations, including that benefit is seen in only a small proportion of people;
- has been provided with a gabapentinoid patient information leaflet outlining the risks of addiction, dependence and withdrawal;
- has been counselled on potential adverse effects and longer-term risks;
- understands the importance of adherence to the agreed dosing regimen;
- understands that medication forms one part of a broader pain management approach, alongside non-pharmacological strategies.

The **treatment plan** should **document**:

- the indication and rationale for treatment;
- relevant clinical findings and non-pharmacological treatments considered, including results from assessment tools, supporting the decision to prescribe;
- details of the prescribed medicine, including choice of drug, planned dose, titration schedule, intended trial duration, monitoring and review schedule;
- the agreed functional treatment goals;
- criteria for continuation or discontinuation, including stopping treatment where there is no meaningful benefit after an adequate trial, where adverse effects are significant, or where there are concerns about misuse, diversion or dependence.

Appendix 2a: GP waiting room poster – Living well with pain

LIVING WELL WITH PAIN

Improve your mental health and wellbeing

Try relaxation, mindfulness, or breathing exercises

Explore cognitive behavioural therapy or pain management programmes

Speak to your GP about mental health support

Maintain a healthy lifestyle

Keep active with walking, swimming, or gentle exercise

Eat a balanced diet and stay hydrated

Aim for good sleep and regular routines

Avoid alcohol and smoking

Look after your social life

Stay connected with friends and family

Join local groups, activities, or hobbies

Ask about social prescribing services

Seek support when you need it

Talk to your GP, pharmacist, or healthcare team

Get a medicines review if pain is ongoing

Visit: www.livewellwithpain.co.uk

QR code

Appendix 2b: Structured consultation when considering gabapentin or pregabalin

1. What else can help with pain?
Before considering gabapentinoids or any medication for pain, it's important to explore non-pharmacological options. These approaches can often provide significant benefit without the potential risks of medications.

Discuss and offer alternatives such as:

- physical therapies (e.g. physiotherapy),
- psychological approaches where available (e.g. ACT, CBT),
- watchful waiting,
- lifestyle interventions,
- self-care: Live Well with Pain has produced Ten footsteps to living well with pain which can be used to encourage engagement in non-medical management[36]. Self-management can also be encouraged through structured pain management programmes and recognised self-education resources (for example Live Well with Pain, Pain Concern information, the Pain Toolkit, and EPP Cymru).

Reinforce that combining non-drug approaches with medication often leads to better outcomes.

Ask the person:

"Other than medication, what have you tried or considered to help with your pain?"

2. Are gabapentinoids suitable for your type of pain?
Gabapentinoids are not appropriate for all pain conditions; prescribe only when the indication is licensed.

Explain to the person:

"We've found that your pain is being caused by a problem with the nerves at the site of your pain, they have become irritated or over-sensitive and are sending stronger pain signals than they should. This is called neuropathic pain. Medicines called gabapentinoids (gabapentin or pregabalin) can sometimes help with this type of pain. Let's talk about whether a gabapentinoid might be suitable for you."

If the pain is low back pain with or without sciatica:
"The pain you're experiencing is due to irritation or pressure on a nerve in your lower back. Although it involves a nerve, gabapentinoids have not been shown to be effective for this type of pain and can cause harm through side effects. The most effective approach is self-management, staying active and doing simple back exercises. Leaflets such as Sciatica and Referred Pain and Exercises for a Better Back *from Backcare provide practical advice."*

Alternative (when not neuropathic):
"Your pain is not being caused by a problem with the nerves. This means gabapentinoids are unlikely to help. Other treatments, such as exercise or physiotherapy, are usually more effective for this type of pain."

3. How well do gabapentinoids work for neuropathic pain?
Neuropathic pain is often chronic and difficult to treat. Only a small proportion of people, around one in nine people taking gabapentin or pregabalin for nerve pain, see any meaningful improvement in their pain[38].

If treatment does not lead to a clear improvement in what the person can do (e.g. activities of daily life, hobbies and social activities), it should be stopped. Being clear about this from the start helps manage expectations and reduces pressure to continue prescribing.

Ask the person:

"What are you hoping this medication will do for you?"

"Are you comfortable trying a medication that may not work for you?"

4. How will gabapentin or pregabalin be started?
Treatment with gabapentin or pregabalin is started as a trial which can last up to 3 months. It's important that the person understands what to expect.

- Treatment starts at a low dose, which is increased slowly, usually each week, to reduce side effects such as dizziness, drowsiness, or unsteadiness.
- The aim is to find the lowest dose that gives a clear improvement in pain and day-to-day function.
- For gabapentin, dose increases can take up to 8 weeks, followed by about 4 weeks at a stable dose.
- For pregabalin, dose increases can take up to 4–6 weeks, followed by about 4 weeks at a stable dose.

A review after the trial period will determine whether to continue or stop treatment.

Ask the person:

"Are you comfortable with a trial period? After that, we can look together at how things are going. If the medicine isn't providing enough benefit, we can agree to stop it."

5. How will we know if the medication is working?
Before starting a gabapentinoid, agree with the person the goals of treatment and the types of functional improvement that they are hoping for and that could be used to assess whether the medicine is working. Emphasise that the aim is not to remove. pain entirely, but to improve function and quality of life. Examples of functional goals include:

- being able to walk to the shops,
- returning to a hobby or social activities,
- sleeping better at night so daily activities can be managed more easily,
- being more independent with daily tasks

Ask the person:

"What activities or aspects of daily life would you like to see improve with treatment?"

6. What if the medication doesn't work?
It's essential that the person understands that:

- if there is no or minimal improvement in functioning after an adequate trial period, the treatment will be discontinued
- absence of pain is not a realistic outcome of treatment
- ongoing reviews will assess whether the medication is still needed.

Discussion should help the person understand that stopping treatment is a responsible and supportive decision when the medication is not effective.

Ask the person:

"Stopping medicines that aren't helping is an important part of managing your pain – do you have any questions about that?"

7. What are the adverse effects and risks?
Gabapentinoids are linked to a range of side effects, and some people are at higher risk of serious harm. As part of shared decision-making, people should be fully informed about the possible risks before starting treatment. Some people may have no side effects at all, while others may experience several side effects at the same time. It's important that people know what to look out for and when to seek review.

Key points to discuss include:

- **Common adverse effects**: dizziness, drowsiness, fatigue and unsteadiness; headache; gastrointestinal symptoms (dry mouth, diarrhoea or constipation); blurred vision; and weight gain or increased appetite. These are frequently reported and are more likely to occur when starting treatment or increasing the dose.
- **Other important adverse effects:** cognitive problems (e.g. confusion or memory difficulties), erectile dysfunction, and mood or behavioural changes. These can affect quality of life and treatment adherence.
- **Long-term risks**: dependence, withdrawal, respiratory depression. The risk of respiratory depression or reduced respiratory drive (e.g. episodes of breath-holding or feeling unable to take a breath without effort) is higher in older people, people with respiratory or neurological conditions, those who are overweight or may have undiagnosed sleep apnoea, and those taking opioids or other CNS depressants.

Use the discussion to emphasise that these medicines carry potential risks and are not without harm.

Ask the person:

"Are you concerned about potential adverse effects or long-term risks?"

8. What should be known about using gabapentinoids safely?
Gabapentinoids are classed as controlled drugs due to their potential for misuse and dependence. It's important to agree from the outset that:

- Gabapentinoids will not be continued if there are concerns about misuse, diversion, or signs of dependence.
- Treatment may be reduced or stopped if the medicine is not providing meaningful benefit or is causing harm.

Key points to highlight:

- Gabapentinoids should never be shared with others.
- They should not be taken in combination with other CNS depressants (e.g. opioids) unless prescribed by a healthcare provider.

Emphasise the importance of using these medicines safely and as agreed.

Ask the person:

"Is there anything you'd like to ask about how to use these medicines safely, or how we might pause or stop them if they aren't helping or are causing harm?"

"Do you understand the importance of not sharing your medication with others?"

Appendix 2c: Patient information leaflet – Gabapentin or pregabalin for pain

Why have I been given this leaflet?

This leaflet helps you decide, with your healthcare worker, if you want to try taking gabapentin or pregabalin to help with your pain. It explains what these medicines do, how well they work, and what to expect if you take them. It is important to understand both the possible benefits and the risks before starting treatment.

What are gabapentin and pregabalin used for?

These medicines are used to treat 'nerve pain', also known as neuropathic pain. Nerve pain can feel different from other types of pain. It may feel like burning, shooting or stabbing pain, tingling or an electric shock. These medicines work by calming the nerves that send pain signals to the brain. This can reduce how strong the pain feels, but they do not cure the cause of the pain.

How well do gabapentin and pregabalin work?

These medicines don't work for everyone. For every nine people who take these medicines, only one person will see an improvement. For most people though, these medicines do not make a big difference to how they feel.

How could gabapentin or pregabalin help?

If the medicine does help, you will usually notice an improvement in what you can do day-to-day, not just in pain levels. Before you start taking the medicine, you and your healthcare worker should agree on a few simple goals that you would like the medicine to help you achieve. For example:

- going for a short walk each day
- sleeping better at night so daily tasks can be managed more easily
- doing hobbies or interests more regularly

These goals will help you and your healthcare worker decide whether the medicine is helping.

What happens if I decide to try gabapentin or pregabalin?

You will usually start this medicine as a trial. This means you try it for a short time to see if it helps. You will start on a low dose which will be increased slowly. This is to reduce any unwanted effects (side effects). A trial can take a few months because it takes time to reach a stable dose.

What side effects might I get?

Like all medicines, gabapentin and pregabalin can cause side effects. Most are mild and tend to go away after a few days.

Common side effects include feeling sleepy, dizzy, or tired, headaches, dry mouth, feeling sick, changes in your bowels (diarrhoea or constipation), blurred vision, weight gain and feeling unsteady when walking.

You may also notice problems with your memory or concentration, or swelling in your legs, ankles or hands.

Talk to your healthcare worker if the side effects:

- last more than a few days,
- are hard to manage,
- make you feel unwell.

What happens after the trial?

Your healthcare worker will ask you about your pain, any improvements in your daily activities and any side effects. They will look at whether the medicine has helped you reach the goals you agreed before starting treatment. This helps you decide together whether the medicine is worth continuing.

What if the medicine doesn't work?

After the trial, if the medicine has not helped you reach your goals, or if the side effects are greater than any help the medicine is giving you, your healthcare worker will advise you to reduce the dose slowly and stop taking it. They will discuss other ways to help manage your pain.

Can I become dependent on these medicines?

Anyone can become physically dependent on these medicines. This means that your body gets so used to it that you may feel unwell if the dose is reduced too quickly or stopped suddenly. If this happens you may experience withdrawal symptoms. They can include headache, sweating, feeling sick, flu-like symptoms, trouble sleeping, or feeling very anxious.

If you start treatment, your healthcare worker should explain how long you might need to take these medicines and how to stop them safely.

Can these medicines cause addiction?

Addiction is different from dependence. It means feeling a strong urge to take the medicine or finding it hard to control how you are taking it. You might feel that you need to continue taking the medicine even when it does not help your symptoms, and you may not realise this is happening at first.

Signs of addiction include:

- craving the medicine;
- feeling that you need to take more than prescribed, take it more often or take it in a different way, even if it is causing unwanted effects on your health;
- needing to take other medicines (for example, other painkillers) to keep getting the same effect;
- taking the medicine for reasons other than what it was prescribed for.

What if I am also taking other pain medicines?

Taking gabapentin or pregabalin with other pain medicines such as codeine, tramadol or morphine can increase the risk of harm. This combination may lead to:

- breathing difficulties (such as breathing becoming slow or feeling unable to get enough air). In rare cases, this can be serious and life-threatening.
- feeling very sleepy or confused.
- dizziness and falls.

Your healthcare worker will consider this and may review your medicine.

If I take gabapentin or pregabalin, when might it be stopped?

Your healthcare worker may need to reduce or stop the medicine if:

- it is not helping you, or
- they see signs of harm, dependence or misuse.

Misuse means taking a medicine in a way other than as prescribed, such as taking higher doses, taking it more frequently, or using it for reasons other than your medical condition.

Can I drive while taking gabapentin or pregabalin?

Gabapentin or pregabalin may make you feel sleepy or dizzy or may slow your thinking. If this happens, do not drive.

Can I drink alcohol while taking gabapentin or pregabalin?

Alcohol can make you feel more sleepy or tired when taking these medicines. It is best to avoid alcohol when you first start taking the medicine. Once you are on a stable dose, you may be able to drink small amounts, but alcohol may still make you more drowsy than usual.

What else can help with my pain?

Medicines are only one part of managing long-term pain. Staying active, taking gentle exercise and having a healthy lifestyle can all help you with your pain. Some people find physiotherapy, pain management programmes, or talking therapies helpful. Your healthcare worker can suggest some options that might be suitable for you.

Visit the AWTTC website for useful links and resources.

Is there anything else I should tell my healthcare worker?

Tell your healthcare worker if you are pregnant, breastfeeding, or planning a pregnancy. Also tell them if you are taking other medicines (including herbal remedies), or if you have ever had problems with alcohol, drugs, or addiction.

Appendix 2d: Medicine initiation template – Gabapentin or pregabalin *

Patient details	
Name:	
DOB:	
NHS No.:	
Date:	
Clinician:	
A. Clinical summary	
Diagnosis:	☐ Neuropathic pain ☐ Other: _____
Assessment:	LANSS score: _____ / 24 (≥12 = likely neuropathic pain) ☐ Clinical assessment
Pain description:	☐ Burning ☐ Shooting ☐ Tingling ☐ Numbness ☐ Electric shock ☐ Other: _____
Duration:	
Functional impact (baseline – tick all that apply):	☐ Sleep disturbance affecting daytime function ☐ Low mood/distress affecting function ☐ Reduced mobility (e.g. walking distance, difficulty standing) ☐ Work/education impact (e.g. off work, reduced hours) ☐ Social participation (e.g. reduced engagement, isolation) ☐ Other: _____
Agreed functional goals (required)	1)_____ 2)_____ 3)_____
B. Previous management	
Medications tried:	☐ Amitriptyline ☐ Duloxetine ☐ NSAIDs ☐ Paracetamol ☐ Opioids (Type/Dose: _____) ☐ Other: _____
Response:	_____ (e.g. ineffective, not tolerated)
Non-pharmacological tried:	☐ Physical activity/exercise ☐ Physiotherapy ☐ Pacing ☐ Pain education programmes ☐ Psychological support (e.g. CBT where available) ☐ Social prescribing (where available) Wellbeing/Self-help resources: ☐ Live Well with Pain ☐ Pain Concern information ☐ ☐ Pain Toolkit ☐ EPP Cymru ☐ Other: _____

*An electronic template is currently being developed to allow access to this form via GP system Optum (previously EMIS).

C. Safety checks (pre-initiation)		
Safety check	**Findings**	**Action/Notes**
Renal function (CrCl)	_____ ml/min	Required before initiation. Adjust dose in renal impairment (risk of accumulation and toxicity). Dose adjustment required if CrCl < 60 ml/min (pregabalin) or < 80 ml/min (gabapentin).
Mental health	☐ No concerns ☐ Depression ☐ Suicidal ideation ☐ Other	Screen for mood disorders and suicidal thoughts. If active risk, avoid or liaise with mental health team.
Substance use/ misuse risk	☐ No ☐ Yes	If there is a history of alcohol dependence, prescription medicine misuse, or substance use, avoid prescribing. Where treatment is considered essential, safeguards must be in place (e.g. limited supply intervals, regular review, and pharmacy support).
Cognitive impairment/falls risk	☐ No ☐ Yes	Increased risk of sedation, confusion and falls. Review polypharmacy (particularly CNS depressants and anticholinergics). Start at low dose, titrate slowly.
Respiratory disease	☐ No ☐ Yes	Increased risk of respiratory depression (even without opioids). Higher risk in COPD, sleep apnoea and with CNS depressants. Avoid co-prescribing where possible, start low dose and monitor closely.
Opioid use	☐ No ☐ Yes	Avoid co-prescribing where possible (increased risk of sedation, respiratory depression and death). Consider dose reduction/taper. Counsel on risks.
Other CNS depressants/ alcohol	☐ No ☐ Yes	Includes benzodiazepines, Z-drugs. Additive sedation and respiratory depression risk. Reduce where possible; advise avoiding alcohol.
Older people/ frailty	☐ No ☐ Yes	Higher risk of adverse effects (sedation, cognitive impairment, falls). Use lower doses and slower titration.
Driving	☐ No ☐ Yes	Warn that gabapentinoids can impair reaction times. People should not drive if drowsy. Follow DVLA guidance.
Pregnancy/ contraception	☐ No ☐ Yes	Advise contraception in women of childbearing potential. Avoid use in pregnancy unless specialist advice.

D. Medication initiated				
Drug	**Starting dose**	**Titration plan**	**Therapeutic dose range**	**Reason for choice**
☐ Gabapentin		Weekly titration preferred in divided doses (e.g. TDS)	Typically, ≥ 1,200 mg/day (in divided doses)	First-line gabapentin
☐ Pregabalin		Weekly titration preferred in divided doses (BD/TDS)	Typically, ≥ 150 mg/day (in divided doses)	Use if gabapentin unsuitable

Prescribing Notes:

- Initiate at a low dose and titrate weekly to minimise adverse effects
- Adjust for renal function (CrCl)
- Consider lower doses and slower titration in older people, frailty, renal impairment, polypharmacy, or known susceptibility to adverse effects
- Consider higher doses (e.g. gabapentin ≥ 600 mg TDS or pregabalin ≥ 150 mg BD) only after review and where some benefit demonstrated
- Maximum doses are not treatment targets – aim for the lowest effective dose
- Do NOT add to repeat until benefit confirmed

E. Counselling and advice (tick all completed)

☐ Purpose and expectations explained
☐ Trial period agreed (up to 3 months, including 4–6 weeks at a stable dose)
☐ Weekly titration schedule discussed
☐ Adverse effects explained
☐ Warned not to stop abruptly (withdrawal risk)
☐ Driving/work safety discussed
☐ Controlled drug responsibilities explained
☐ Importance of non-pharmacological management reinforced
☐ Review and stopping plan agreed

F. Follow-up plan	
Review	Due in _____ weeks
At review assess:	Primary outcome: ☐ Functional improvement (based on agreed goals) Secondary outcomes: ☐ Pain relief Safety: ☐ Adverse effects ☐ Signs of misuse, dependence or diversion
Decision (based on benefit vs harm):	☐ Continue (ONLY if functional improvement demonstrated) ☐ Maintain lowest effective dose ☐ Taper and stop (if no meaningful benefit after trial) ☐ Refer to musculoskeletal/pain specialist if complex case

Appendix 2e: Patient trial plan – Gabapentin or pregabalin

What do you want to get from this trial?

What is your goal (something to work towards) during the trial? For example, do more daily tasks, return to a hobby, take a short walk each day, or spend more time out of the house.

What medicine will you be taking for your trial?

Medicine name: _____

Fill in the table below with the numbers of tablets you should take, and when you should take them.

Date	Morning dose	Midday dose	Evening dose

Date of your review (This should be within 6 to 8 weeks of starting the trial)

_____

Warning: Gabapentin and pregabalin are associated with significant risks, including side effects, dependence, and addiction. These medicines must be reviewed regularly and reduced and stopped if the risks outweigh the benefits.

A positive outcome to a gabapentin or pregabalin trial does not indicate that the medicine will continue to be helpful in the long term.

Please return all unused medicines to your local pharmacy.

Appendix 2f: Treatment agreement plan – Gabapentin or pregabalin

Patient name: _____**Date:** _____

Medicine: ☐ Gabapentin ☐ Pregabalin

Why this medicine is being considered?
Gabapentin or pregabalin may be used for nerve (neuropathic) pain, but they do not help everyone and can cause harm. Only about 1 in 9 people experience improvement. For this reason, treatment is started as a trial and will only be continued if there is clear functional benefit.

Possible risks and side effects
I understand that gabapentin or pregabalin can cause:

- Sleepiness, dizziness, poor concentration or balance problems;
- Dependence, where the body gets used to the medicine at prescribed doses, which can make it hard to stop;
- Addiction, which can develop gradually and means feeling a strong urge to take the medicine or finding it hard to control how much you use it;
- Increased risk of serious harm, including breathing problems especially if taken with opioids (e.g. morphine, codeine), benzodiazepines (e.g. diazepam), Z-drugs (e.g. zopiclone), or other CNS depressants.

Agreed functional goals (what success looks like, agree 2–3 specific goals)
1._____

2._____

3._____

Non-pharmacological management
Medication is **one part** of pain management. The following have been discussed and agreed: ☐ Physical activity/physiotherapy ☐ Pacing/activity management ☐ Psychological support ☐ Sleep support ☐ Supported self-management ☐ Education/advice ☐ Other: _____

Review and stopping plan

- Planned review date: _____
- Treatment will only be continued if there is clear functional benefit in line with the agreed goals.
- Treatment will be reduced and stopped if:
    - agreed functional goals are not achieved or maintained, or
    - side effects, safety concerns, misuse or dependence arise.

This agreement plan will be kept in your records and referred to during treatment. Please tick each box to confirm understanding:

☐ I understand this medicine may not help my pain.

☐ I understand the potential risks and side effects.

☐ I understand treatment will only continue if there is clear functional benefit.

☐ I understand the medicine will be stopped if it does not help or causes harm.

☐ I agree to attend reviews and follow the agreed treatment plan.

Patient signature: _____

Prescriber name & signature: _____

Resource pack 3: Reviewing gabapentinoid use

Summary guide – Resource pack 3: Reviewing gabapentinoid use

1. Identifying people for review

- Prioritise people at higher risk: high or escalating doses, long-term use without recent review, co-prescribed opioids/CNS depressants, older or frail adults, renal impairment, multiple comorbidities, or history of substance use/alcohol dependence.
- Review off-label use: non-neuropathic pain or undocumented indications.
- Support engagement by sending letters, adding leaflets or messages to repeat prescriptions, and reinforcing key safety messages in routine consultations.

2. Planning reviews

- Incorporate analgesic reviews into annual medication reviews, hospital discharge reconciliations and opportunistic contacts.
- Use codes (e.g. Chronic Pain Review) to record next review dates and document plans clearly in the GP prescribing system.
- Set expectations at initiation or dose change, prepare people before inviting them, and advise pre-operative people that analgesics will be reassessed after surgery.

3. Conducting reviews

- Reassess the original indication and confirm it remains appropriate.
- Evaluate effectiveness (pain relief, functional outcomes, sleep, wellbeing) and review adverse effects, renal function and co-prescribed opioids/CNS depressants.
- Check adherence and patterns of use, signs of dependence, misuse or diversion.
- Engage in shared decision-making to determine continuation, reduction or stopping; consider shorter prescribing intervals with brief check-ins for people at higher risk.

4. Whole-practice approaches

- Use treatment agreements for new patients and provide locums with concise guidance on practice expectations and when to seek senior input.
- Apply simple system measures such as removing items from repeat list that haven't been ordered for several months, shortening reauthorisation intervals, using electronic prompts or templates to support safe review, and avoiding repeat prescriptions until benefit is confirmed.
- Nominate a lead prescriber for initiation and review and discuss complex or higher-risk cases collectively to maintain shared standards.
- Feedback concerns about inappropriate recommendations to secondary care providers where appropriate.

5. Non-drug and supported self-management options

- Discuss non-pharmacological options such as physiotherapy, exercise-based rehabilitation, and pain-management programmes where available.
- Where suitable, consider referral to social prescribing services, which can link people with wellbeing support, community groups, physical-activity programmes, and advice services.
- Ensure people understand that non-drug interventions support but do not replace medical care.

3.0 Reviewing gabapentinoid use

Treatment should be reviewed regularly to assess effectiveness, safety and adherence. Early review should assess pain, function and tolerability. Longer-term reviews should occur every six to twelve months.

3.1 Rationale for review

Early improvement during a gabapentinoid trial does not mean the treatment will remain helpful over time. With continued use, gabapentinoids can cause problems such as sedation, dizziness, falls, cognitive effects, respiratory depression, misuse, dependence and withdrawal. Regular review is needed to confirm that benefit is maintained and to identify emerging harm and to determine whether treatment remains appropriate. Where benefit is unclear or adverse effects increase, dose reduction or discontinuation should be considered. Non-pharmacological approaches should also be reviewed, as these may improve function and reduce reliance on long-term medication.

Supporting tools for review:

- Appendix 3a: Patient information leaflet – Reviewing your gabapentin or pregabalin for pain can be shared with the person to support understanding and engagement ahead of review.
- Appendix 3b: Patient medication questionnaire – Pregabalin or gabapentin can be completed by the person before each review appointment to capture their current experience, helping to structure a focused, person-centred review.
- Appendix 3c: Medication review template – Gabapentin and pregabalin can be used to guide and record the clinical review, ensuring all relevant safety and effectiveness aspects are considered.

Audit tools for prescribing reviews are provided in Section 5.0 to support safe and appropriate prescribing practices. These include adaptable templates, letters and patient-facing messages to facilitate both routine medication reviews and targeted audits, such as those for people at higher risk or with renal impairment.

3.2 Identifying people for review

All people prescribed gabapentinoids should be reviewed at least annually; however, priority should be given to people at higher risk, including those listed below:

Higher priority for review

Higher-risk prescribing:

- High doses or rapid dose escalation
- Co-prescribing with opioids or other CNS depressants (e.g. benzodiazepines, Z-drugs)
- Older or frail people, or those at increased risk of falls
- Renal impairment or other relevant comorbidities
- History of substance use or alcohol dependence

Concerning prescribing patterns:

- Infrequent ordering despite being on repeat prescription
- Reports of lost medication or repeated urgent requests
- Long-term use without recent review

Unclear or off-label indications:

- Use for non-neuropathic pain
- Uncertain or undocumented original diagnosis

3.3 Planning reviews

Practical approaches to reviews

Integrating reviews into routine processes

- Annual medication reviews
- Hospital discharge medicine reconciliation
- Opportunistic reviews during routine appointments

Coding

- Use of consistent codes (e.g. Chronic Pain Review) to ensure follow-up
- Documentation of review dates within the prescribing system
- Recording agreed plans on prescription notes or repeat slips

Setting expectations early

- Agree a review date at initiation or dose change.
- Ensure people understand that ongoing treatment depends on demonstrable improvement.
- Where possible avoid “cold calling” people for review by preparing them in advance.
- Advise pre-operative people that analgesics will be reviewed after surgery.

In people receiving palliative care, reviews should focus on functional benefit, safety and harms, and advice should be sought from specialist services where appropriate.

3.4 Review during the trial period

3.4.1 Early treatment and stabilisation

During the initial trial period, people prescribed gabapentinoids should be reviewed during dose titration and after a stable dose is reached to assess tolerability and benefit. Reviews may be undertaken by telephone or other remote methods where appropriate.

Review frequency (guide):

- during titration, any increases resulting in doses of gabapentin ≥ 600 mg three times daily or a pregabalin dose of ≥ 150 mg twice daily should only occur following review and where functional benefit has been demonstrated;
- 4–6 weeks after a stable dose is achieved, to determine whether treatment should continue.

At each review assess:

- adverse effects, tolerability, and adherence,
- benefit against agreed functional goals (e.g. daily activities, mobility, or sleep where this supports daytime function).

3.4.2 Evaluating outcomes of the trial

After a stable dose is reached, a review should be carried out to decide whether treatment should continue. At review, prescribers should:

- Confirm whether the agreed functional goals have been achieved.
- Continue treatment only where functional improvement is demonstrated and prescribe the lowest dose at which benefit is achieved.
- Only consider dose increases where some functional improvement has been demonstrated and the treatment is well tolerated; maximum doses are not a target, do not improve outcomes and may increase the risk of misuse.
- Consider dose reduction where benefit is limited or unclear.
- Where treatment continues, consider short-duration prescriptions to support monitoring and reduce the risk of misuse or diversion.
- Avoid adding gabapentinoids prescribed for pain on repeat prescription without planned review.

Lack of benefit during trial

If improvement in pain and function is not seen within the trial period, ongoing benefit is unlikely and the potential for harm increases; **treatment should be gradually reduced and stopped**.

3.4.3 Switching between gabapentin and pregabalin

Gabapentin and pregabalin act in similar ways therefore switching between them is unlikely to provide additional benefit if one has been ineffective. Both medicines carry a risk of misuse and dependence, with pregabalin associated with a higher risk of harm at high doses. These risks should be carefully considered before any switch is undertaken. In some cases, it may be more appropriate to discontinue therapy and consider alternative pain management strategies.

If switching between gabapentinoids is considered appropriate (for example, because of intolerable adverse effects rather than lack of efficacy), guidance is available from the Specialist Pharmacy Service (SPS): Switching between gabapentin and pregabalin for neuropathic pain.

3.5 Review of long-term use

People established on a gabapentinoid should be reviewed regularly to check whether the benefits previously experienced are maintained and whether harms are emerging, and to decide if treatment should continue. Table 10 provides a suggested frequency for review.

Table 10. Suggested review frequency based on individual risk

Patient group	Suggested review frequency
Stable patients	Every 6–12 months
Concurrent opioids	Every 3–6 months
People at high risk (e.g. with substance use, mental health conditions)	Every 2–4 weeks
Off-label use: non-neuropathic conditions (e.g. non-specific back pain)	Prioritise reviews and aim to reduce and stop where appropriate.

Structured review: key elements

Preparation

- Provide the person with information beforehand to support shared decision-making (use Appendix 3a: Patient Information Leaflet: Reviewing your gabapentin or pregabalin for pain).

Clinical assessment

- Assess whether the treatment is providing benefit against the agreed functional goals.
- Check the original reason for prescribing remains appropriate.
- Ask the person about problems they are experiencing (e.g. weight gain, sedation, cognitive or balance issues) and consider whether these may be related to long-term gabapentinoid use, as people may not recognise them as adverse effects.
- Review renal function and adjust dose if required.
- Assess risk of respiratory depression, particularly in people with respiratory disease (e.g. COPD, sleep apnoea) and in those prescribed opioids or other CNS depressants.
- Check for concurrent use of opioids or other sedative medicines, reduce doses and discontinue where appropriate.
- Check for patterns suggesting misuse or diversion.
- Consider wider concerns including polypharmacy.

Consideration of patient factors

- Explore expectations and what matters most to the person at this stage of treatment.
- Revisit the agreed functional goals and whether these are still relevant.

Consideration of changes where appropriate

- Where benefit is uncertain consider a planned trial dose reduction to assess ongoing need.
- Many people with stable symptoms can reduce their dose without worsening pain or function.
- Where appropriate, aim to trial dose reduction or stopping every 6–12 months.

Explore alternatives

- Discuss non-pharmacological approaches already in use and any additional support that may be helpful.
- Where switching between gabapentinoids is considered appropriate, guidance is available from the SPS: Switching between gabapentin and pregabalin for neuropathic pain.

3.6 Criteria for continuing or discontinuing treatment

A decision to continue or discontinue treatment should be based on thorough assessment of risks and benefits. Table 11 outlines the main criteria for decision making.

Table 11. Criteria for continuing or discontinuing treatment

Criteria for continuing gabapentinoid treatment All the following criteria must be met:	**Criteria for discontinuing gabapentinoid treatment** Any of the following are met:
A current, appropriate indication remains e.g. confirmed neuropathic pain.	There is no appropriate indication for continued gabapentinoid use.
There is benefit against agreed functional outcomes, such as improved ability to carry out daily activities or improved mobility.	Agreed functional outcomes have not been met
Adverse effects are absent or acceptable.	Adverse effects have developed, including sedation, falls or weight gain.
There are no contraindications or cautions related to other medicines or comorbidities.	Co-prescribing with opioids, benzodiazepines, Z-drugs or other CNS depressants raises safety concerns.
There are no concerns about dependence, misuse or diversion.	There are concerns about dependence, misuse or diversion.

3.7 Documentation at review

At each review, record:

- The current dose, response to treatment, adverse effects, goal-based assessment, and whether treatment is to continue or be reduced.
- The planned date for the next review.
- The agreed functional outcomes used to support the decision, including reasons for continuation or discontinuation (see Resource pack 4 for reducing treatment).

3.8 System measures to support reviews

Whole-practice approaches to support gabapentinoid deprescribing

Electronic support tools

- Prescribing decision prompts that highlight key safety considerations and risks, such as concurrent opioid, benzodiazepine, Z-drug or other CNS depressant use, renal impairment, or high doses.
- Alerts for overdue reviews, escalating doses or frequent early requests.

Repeat prescription management

- Shortened reauthorisation intervals (24–25 days) to reduce early ordering or excessive ordering.
- Removal of repeat items not requested for several months to prevent unintentional continuation or stockpiling.
- Safety messages on repeat slips reminding people of review requirements.
- Where possible use of digital platforms such as the NHS App to share similar prompts or reminders.

Team-based governance

- A nominated lead prescriber overseeing initiation, titration and complex reviews.
- Partner/senior sign-off for dose increases beyond agreed thresholds.
- Multidisciplinary team discussion of complex cases or people at higher risk.

- Communication with secondary care where prescribing recommendations raise safety concerns.

Locum and new-starter support

- A concise practice prescribing guide describing practice expectations for initiation, titration and review.
- Clear expectations on avoiding new initiations or escalations without review.

Appendix 3a: Patient information leaflet – Reviewing your gabapentin or pregabalin for pain

Why review my medicine?

It is important to review your medicine regularly to make sure it is still helping and not causing problems. This review will help you and your healthcare worker to decide if you should continue taking, change, reduce, or stop taking your medicine.

Why is it important to attend my review appointments?

If you are not reviewed, your healthcare worker may not have enough information to decide whether it is safe and appropriate to continue prescribing this medicine.

If you are unable to attend, please let your healthcare team know so another appointment can be arranged.

What will we discuss at my review?

- How the medicine might be helping your pain.
- Any unwanted effects (side effects) caused by the medicine.
- How you are feeling in general (such as: your mood, sleeping, memory, energy levels).
- If the medicine is helping you do day-to-day activities more easily, such as walking a bit further, managing household tasks or doing more of the things you enjoy.
- If your dose is right for you.
- If you have had any problems taking your medicine (like forgetting doses or feeling drowsy).
- If it is still safe and helpful for you to carry on taking your medicine.

How do I know if the medicine is working?

Gabapentin or pregabalin may help reduce pain but don't remove it completely. When reviewing the medicine, it is important to look at function as well as pain. For example:

- Are you able to move around more easily?
- Are you able to get back to a hobby?
- Are you managing daily tasks more easily?

If you notice an improvement in what you are able to do, you and your healthcare worker will agree whether to continue the medicine at the same dose, change the dose, or try to gradually reduce the dose to see if you still need it.

What if the medicine isn't helping?

If your pain hasn't improved and you haven't noticed any change in what you can do, the medicine may not be right for you.

You and your healthcare worker may decide to reduce the dose or stop it. This is usually done gradually to see if you still need it and to avoid side effects.

Can I stop taking this medicine straight away?

No. If you suddenly stop taking your medicine, you may feel unwell because you are experiencing withdrawal symptoms. This can happen because your body has got used to the medicine. You may feel anxious, have a headache, feel sick, sweat more, or have flu-like symptoms.

What else can help with my pain?

Medicines are only one part of managing long-term pain. Staying active, taking gentle exercise and having a healthy lifestyle can all help you with your pain. Some people find physiotherapy, pain management programmes, or talking therapies helpful. Your healthcare worker can suggest some options that might be suitable for you.

Visit the AWTTC website for useful links and resources.

What if I have concerns before my next review?

If your pain gets worse, or if you feel the medicine is causing problems, tell your GP, nurse, pharmacist or other healthcare worker. **Do not wait until your next review.**

Appendix 3b: Patient medication questionnaire – Gabapentin or pregabalin

To be completed before your medication review appointment. Your answers will help your healthcare provider understand how this medicine is affecting you – what's helping, what's not, and what changes you might want to consider.

1. Your medicines	
Which medicine are you taking?	☐ Gabapentin ☐ Pregabalin ☐ Not sure
How long have you been taking it?	
Why was it prescribed?	☐ Nerve pain ☐ Fibromyalgia ☐ Back pain ☐ Other: _____

2. How well is it working?											
Please rate each area on a scale from 0 (not helping at all) to 10 (helping a lot):											
	0	1	2	3	4	5	6	7	8	9	10
Pain relief	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Daily activities (e.g. moving, self-care, work)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sleep/ mood	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

3. Side effects		
Have you noticed any of these? (tick all that apply)	☐ Breathing difficulties ☐ Feeling sleepy ☐ Dizziness ☐ Tiredness/low energy ☐ Problems with memory or concentration ☐ Poor balance or falls ☐ Weight gain or increased appetite ☐ Changes in mood (e.g. low mood, irritability)	☐ Swollen ankles, feet or hands ☐ Changes in bowel habits (e.g. constipation or diarrhoea) ☐ Dry mouth ☐ Headaches ☐ Blurred vision ☐ Other: _____
Have side effects affected your daily life or wellbeing?	☐ Yes (explain: _____) ☐ No	

4. Withdrawal or missed doses	
If you miss or reduce a dose, do you notice: (tick all that apply)	☐ Pain getting worse ☐ Sweating ☐ Feeling unwell (flu-like) ☐ Feeling sick ☐ Shaking or trembling ☐ Trouble sleeping ☐ Feeling anxious, restless or low ☐ Fast or pounding heartbeat ☐ Headache ☐ Other: _____
5. Your experience and goals	
Biggest positives of this medicine:	
Biggest downsides or concerns:	
What matters most to you right now?	☐ Improve daily life and function ☐ Reduce side effects ☐ Reduce or stop the medicine ☐ Try something else ☐ Stay on this medicine ☐ Support with mood or mental wellbeing ☐ Other _____
Would you like to discuss any of these?	☐ Exercise (at your own pace) ☐ Physiotherapy ☐ Doing activities in small amounts ☐ Pain education programmes ☐ Sleep/lifestyle support **Wellbeing / Self-help Resources:** ☐ Live Well with Pain ☐ Pain Concern information ☐ ☐ Pain Toolkit ☐ EPP Cymru ☐ Other: _____
Anything else you'd like to share:	

Appendix 3c: Medication review template – Gabapentin and pregabalin †

Patient name: _____ DOB: _____ Date: _____

Clinician name: _____ NHS No.: _____

1. Purpose of review
"We're reviewing how your medicine is working for you, including benefits, side effects, and whether it's helping your day-to-day life. We can decide together whether to continue, adjust, or try something different."

2. Current medication				
Medication	**Dose**	**Frequency**	**Start date**	**Prescribing reason**

3. Functional goals of treatment	
Prompt: "When this medicine was started, what were we hoping it would help with? And how is that going now?"	
Patient goals:	

4. Medication effectiveness	
Prompt: "Let's look more closely at how the medicine is helping day-to-day."	
Medicine helping with?	**Tick all that apply**
Pain relief (%)	☐ 0 ☐ 10 ☐ 20 ☐ 30 ☐ 40 ☐ 50 ☐ 60 ☐ 70 ☐ 80 ☐ 90 ☐ 100
Helps during flare-ups	☐ Yes ☐ No ☐ Partially
Mood or wellbeing	☐ Yes ☐ No ☐ Partially
Supports daily activity (e.g. moving, washing, dressing)	☐ Yes ☐ No ☐ Partially
Social activities (e.g. seeing people, going out)	☐ Yes ☐ No ☐ Partially
Work or usual daily roles	☐ Yes ☐ No ☐ Partially
Helps you sleep better (so you function better in the day)	☐ Yes ☐ No ☐ Partially
Still meeting original functional goals	☐ Yes ☐ No ☐ Partially

†An electronic template is currently being developed to allow access to this form via GP system Optum (previously EMIS).

5. Adverse effects or concerns	
Prompt: “Have you had any unwanted effects that might be linked to this medicine?”	
Adverse effects	**Experienced? Tick all that apply**
Drowsiness/dizziness/fatigue	☐ Yes ☐ No
Balance problems or falls	☐ Yes ☐ No
Cognitive effects (e.g. memory problems, feeling slowed down)	☐ Yes ☐ No
Weight gain or increased appetite	☐ Yes ☐ No
Mood changes (e.g. low mood, irritability, anxiety)	☐ Yes ☐ No
Blurred vision or visual disturbance	☐ Yes ☐ No
Changes in bowel habit (e.g. constipation or diarrhoea)	☐ Yes ☐ No
Swelling of feet, ankles or hands	☐ Yes ☐ No
Breathing difficulties (e.g. breath-holding or episodes where people feel they must initiate breathing)	☐ Yes ☐ No
Other (patient reports):	

6. Dependence/withdrawal features
Prompt: “Any symptoms if you miss a dose or try cutting down?”
☐ Anxiety/restlessness ☐ Tremor ☐ Sweating ☐ Muscle aches/‘flu-like’ ☐ Rebound pain ☐ Nausea ☐ Other: _____

7. Patient reflections: benefits vs downsides	
“Looking at everything, do you feel this medicine is still helping more than it’s causing problems?”	
Benefits (+)	**Problems (–)**
☐ More benefits ☐ More problems ☐ Mixed/unclear	

8. Non-pharmacological options		
“Sometimes combining medicine with other tools works even better. Let’s look at what you’ve tried or might be open to.”		
Option	**Already using?**	**Offer/refer?**
Pain education programmes	☐ Yes ☐ No	☐ Yes ☐ No
Psychological support e.g. CBT if available	☐ Yes ☐ No	☐ Yes ☐ No
Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No
Sleep/stress management	☐ Yes ☐ No	☐ Yes ☐ No
Mindfulness/pacing	☐ Yes ☐ No	☐ Yes ☐ No
Self-management resources e.g. Living Well with Pain, Pain Concern information, Pain Toolkit or EPP Cymru	☐ Yes ☐ No	☐ Yes ☐ No

9. Clinical safety and deprescribing		
Risk area	**Present?**	**Action prompt if present**
Renal impairment	☐ Yes ☐ No	Check CrCl → adjust dose; accordingly, consider dose reduction if adverse effects
Concomitant opioid use	☐ Yes ☐ No	Increased risk of sedation and respiratory depression → consider dose reduction or taper of one or both
Other CNS depressants (e.g. benzodiazepines, Z-drugs)	☐ Yes ☐ No	Review need and reduce total sedative load where possible
Respiratory disease (e.g. COPD, sleep apnoea)	☐ Yes ☐ No	Increased risk of respiratory depression → use caution; consider dose reduction
High dose without clear benefit	☐ Yes ☐ No	Reassess effectiveness → consider reducing dose
Frailty or falls risk	☐ Yes ☐ No	Increased risk of falls and harm → consider lower dose or alternative; review need
Cognitive impairment	☐ Yes ☐ No	Risk of confusion and harm → review need
Substance use/misuse risk	☐ Yes ☐ No	Consider safer alternatives/ mental health support
If ANY of the above are checked “Yes”, consider ☐ Gradual dose reduction ☐ Reduce dose to lowest effective level ☐ Switch to alternative treatment ☐ Increase monitoring (e.g. review sooner) ☐ Refer to: ☐ Mental health ☐ Pain team ☐ Falls team ☐ Respiratory		

10. Planning together – shared options		
Prompt: “Let’s decide together what the best next step is. Sometimes medicines can cause more harm than good over time. Would you be open to making changes gradually?”		
Option	**Tick**	**Notes**
Continue current dose (only if meaningful benefit)	☐	Maintain lowest effective dose
Adjust dose (increase or reduce as appropriate)	☐	↑ only if some benefit; ↓ if adverse effects
Gradual dose reduction (if no meaningful benefit or harms outweigh benefits)	☐	Use stepwise taper
Switch to alternative medicine	☐	Consider if not tolerated
Focus on non-pharmacological support	☐	Reinforce activity, pacing, support
Other plan:	☐	

11. Follow-up and support	
Next review date:	
Resources shared today:	☐ Live Well with Pain ☐ Pain Concern information ☐ Pain Toolkit ☐ EPP Cymru ☐ Other _____

Resource pack 4: Reducing and stopping a gabapentinoid

Summary guide – Resource pack 4: Reducing and stopping a gabapentinoid

1. Indications for reduction or stopping

- Lack of meaningful improvement in pain or function after a therapeutic trial, or when the original indication has resolved.
- Development of adverse effects such as sedation, dizziness, weight gain, or cognitive impairment.
- Concurrent opioid, benzodiazepine or Z-drug use that increases risk of overdose and respiratory depression or reduced respiratory drive. Evidence or suspicion of misuse, diversion, or dependence.

2. Shared decision-making

- Explore the person's fears, expectations and concerns about reducing, and address these before planning any change.
- Explain that long-term benefits are uncertain, while risks such as sedation, falls, and dependence increase over time.
- Agree functional goals such as improved alertness, reduced falls, or fewer adverse effects. Provide written information and personalised tapering plan.
- Discuss non-drug options such as pacing, movement, sleep and mood support, physiotherapy, pain programmes and social prescribing (where available), while acknowledging variation in local service availability.

3. Principles of safe tapering

- Reduce doses gradually (e.g. by 50–100 mg pregabalin or 100–300 mg gabapentin, or approximately 10% of the total daily dose) every 1–2 weeks. Tailor tapering speed to the dose, duration, comorbidities, and tolerance.
- Go slower where people have long-term use, higher doses, frailty, or significant anxiety about reduction.
- Avoid abrupt discontinuation, which increases the risk of withdrawal.

4. Managing withdrawal symptoms

- Possible withdrawal symptoms include anxiety, agitation, irritability, headache, tremor, insomnia, sweating, gastrointestinal disturbance, nausea, pain rebound and, in rare cases, seizures.
- If symptoms are severe, pause the taper and stabilise at the current dose before resuming more slowly.
- Offer supportive strategies such as reassurance, sleep hygiene, relaxation techniques, and referral for psychological support if needed (e.g. ACT or CBT based approaches where available).
- Consider wellbeing resources, self-management through structured pain management programmes and self-education resources (for example Live Well with Pain, Pain Concern information, the Pain Toolkit, and EPP Cymru).

5. Documentation and follow-up

- Record the reason for reduction, the agreed plan, and patient consent.
- Document the tapering schedule and provide a written copy to the person.
- Arrange regular follow-up appointments to review progress, withdrawal symptoms, and functional outcomes.
- Ensure outcomes are recorded, including whether treatment was stopped, continued, or alternative therapies were introduced.

4.0 Reducing and stopping a gabapentinoid

Guidance from the General Medical Council[45] and NICE (NG215)[46] emphasises that prescribers must act in the person's best interests, which may include reducing or stopping a gabapentinoid even where this is not the person's preference. In practice, discontinuation is achievable for most people with gabapentinoid dependence when the risks of prolonged use and the benefits of stopping are clearly explained and discussed.

Share Appendix 4a: Patient information leaflet: Reducing gabapentin or pregabalin for pain. It explains why tapering is considered, outlines the importance of gradual reduction, and includes a template reduction plan.

4.1 Principles of safe reduction

- Shared decision-making: Discuss concerns and expectations, functional goals, and explain why dose reduction is being considered (limited long-term benefit and increasing risk over time).
- Flexible pace: Set the reduction speed based on dose, duration of use and overall health. Pause or slow the taper if withdrawal symptoms occur.
- Gradual reduction: As a general guide the dose should be reduced every 1–2 weeks, adjusting as needed based on symptoms.
- Safety advice: Explain tolerance reduces rapidly; returning to previous higher doses after reduction increases risk of overdose and respiratory depression.
- Support: Encourage non-drug approaches to pain management.

4.2 Indication for reduction or discontinuation

Circumstances prompting reduction or discontinuation

Lack of benefit:

- No improvement in pain or function after a therapeutic trial.
- Long-term use without clear ongoing benefit.

Resolved or inappropriate indication:

- The original painful condition has improved or resolved.
- Use for non-neuropathic pain or off-label indication without benefit.

Adverse effects or safety concerns:

- Side effects such as sedation, dizziness, cognitive impairment, weight gain, declining renal function or reduced respiratory drive.
- Co-prescribing with opioids, benzodiazepines, Z-drugs or other CNS depressants.
- Worsening of comorbidities (e.g. depression, sleep apnoea, frailty).

Misuse or dependence risks:

- Evidence, or strong suspicion, of misuse or diversion, including obtaining supplies elsewhere.
- Concerns raised by healthcare professionals, family or carers.

Patient preference:

- The person wishes to reduce or stop treatment.

Routine consideration:

- Consider every 6–12 months for people on long-term treatment for pain.
- Where possible, after improvement in pain and function following dose stabilisation.

4.3 Preparing the person for tapering

Key discussion points

Rationale for reduction:

- Explain that long-term benefit is often limited and risks such as dependence increase with time.
- Highlight dose reduction may lead to improved cognition, more energy and improved overall functioning.

Timing of reduction:

- Where possible, begin dose reduction during a period of relative stability, taking account of mental health and wider circumstances.
- A practical tip is to begin reductions early in the week, ensuring support is available if symptoms emerge.
- Unnecessary delay should be avoided where treatment is ineffective or causing harm.
- Emphasise this is not stopping treatment – it's changing the approach.

Ongoing pain management:

- Agree how pain will be managed during dose reduction, including non-pharmacological approaches.
- Where available, consider referral to social prescribing or community wellbeing services, recognising that access and waiting times may vary.

Withdrawal symptoms:

- Explain that withdrawal symptoms may occur, including anxiety, sleep disturbance, sweating, nausea or pain flares.
- These are usually temporary and manageable.
- The pace of reduction can be adjusted if symptoms arise.

Agree outcomes of tapering:

- This may involve reducing to the lowest effective dose, rather than stopping treatment completely, to minimise adverse effects.

4.4 Tapering approach and schedule

Suggested reduction schedules for gabapentin and pregabalin are shown in Table 12. The manufacturers recommend pregabalin and gabapentin are discontinued gradually, over at least one week[4,5]. A more gradual dose reduction allows observation of emergent symptoms that may have been controlled by the drug and is likely to be better tolerated by the person.

Table 12. Suggested reduction schedules for gabapentin and pregabalin

Drug	Reduction schedule
Gabapentin (Total daily dose > 900 mg)	Reduce total daily dose by 300 mg every 2 weeks (range 7–14 days)
Gabapentin (Total daily dose ≤ to 900 mg)	Reduce total daily dose by 100 mg every 2 weeks (range 7–14 days)
Pregabalin	Reduce total daily dose by 50–100 mg every 2 weeks (range 7–14 days)

Notes

- An alternative regimen is to reduce by around 10% of the total daily dose every 7–14 days, re-calculating the dose at each step. Reductions should be individualised, made no more frequently than weekly, and adjusted according to patient tolerability. Dose adjustments should take into account the available formulations.
- Gabapentin is available as 100 mg, 300 mg and 400 mg capsules, and 600 mg and 800 mg tablets. The liquid formulation should be avoided, as levels of propylene glycol, acesulfame K and saccharin sodium may exceed recommended WHO daily intake limits in low weight adults, potentially leading to electrolyte disturbances[47].
- Pregabalin is available as 25 mg, 50 mg, 75 mg, 100 mg, 150 mg, 200 mg, 225 mg and 300 mg capsules and tablets. The liquid formulation should generally be avoided due to its comparatively high cost.

Risk of overdose following tapering

Warn the person of the **risk of overdose or death** if a higher dose of gabapentin or pregabalin is taken following tapering as **tolerance is reduced**.

4.5 Management of withdrawal symptoms

- If withdrawal symptoms occur (e.g. anxiety, insomnia, sweating or nausea), slow the taper by using smaller dose reductions or increasing the interval between changes.
- Slower tapering schedules (e.g. monthly reductions) are often associated with fewer withdrawal problems, particularly when using small dose reductions (e.g. 100 mg for gabapentin or 25 mg for pregabalin).
- A temporary pause at the current dose may help symptoms to settle.
- Re-escalation to a higher dose is rarely required; symptoms can usually be managed by adjusting the speed of tapering.
- Advise against taking extra doses during periods of stress or increased pain, as this increases the risk of overdose.

4.6 Re-emergence of neuropathic pain

- A mild or temporary increase in pain symptoms can occur and does not necessarily mean a gabapentinoid is still required. This may reflect short-term effects of dose reduction or natural fluctuation in chronic pain rather than ongoing benefit from the medicine.
- Encourage the use of non-pharmacological strategies and self-management approaches.
- As the dose is reduced, each step down represents a larger proportion of the remaining dose. Reductions may therefore feel more difficult at lower doses and people may experience returning pain. If this happens, consider smaller reductions as the dose decreases but avoid unnecessarily prolonging tapering.
- If pain continues, consider holding the current dose for longer and review the overall pain pattern and function. Advise against extra doses as this increases this risk of overdose.
- If complete withdrawal of treatment is not successful, consider maintaining the current dose in the reduction regimen. Discuss long term goals and non-pharmacological management. Re-attempt tapering in 3–6 months depending on patient and clinical factors.

4.7 Reviews during taper

The timing of reviews should be agreed between the prescriber and the person. At each review:

- Ask about any withdrawal symptoms or new symptoms they may be experiencing.
- Check for changes since the last dose reduction including any improvement in pain, function, or overall wellbeing.
- Agree whether to continue reducing, pause, or maintain the current dose, based on the person's response and readiness.
- Review use of non-pharmacological pain-management strategies and encourage continued engagement.

4.8 Resistance to reduction

The General Medical Council (GMC) guidance, *Good practice in proposing, prescribing, providing and managing medicines and devices*, notes that doctors should decline to prescribe medication if they do not believe it is safe, clinically indicated, or in the person's best interests[48]. Where concerns arise about ongoing prescribing, this should be addressed through open and honest communication with the person.

Resistance to tapering is common and discussions about dose reduction can be challenging. The first and most important step is to explore *why* the person is reluctant. Understanding their fears, expectations and previous experiences allows the prescriber to address concerns directly, build trust and work towards a shared and appropriate plan of care.

Addressing reluctance to reduction

- **Explore the person's concerns:** Ask what they are worried about (e.g. pain worsening, withdrawal, loss of control, past failed reductions). Validate these concerns and provide clear information.
- **Address misconceptions or fears:** Explain that dose reduction is gradual, flexible, and can be paused. Reassure the person that pain flares or withdrawal symptoms can be managed and that support will be available.
- **Agree a small "test" reduction:** A minor decrease can help the person experience that symptoms often remain stable, increasing confidence in the process.
- **Offer gradual, flexible reductions:** Provide a clear plan, adapt the pace as needed, and maintain frequent contact (e.g. telephone or brief in-person reviews).
- **Reinforce holistic support:** Emphasise the use of non-drug approaches, such as pacing, sleep and mood support, physiotherapy, rehabilitation, and social prescribing where available.

Where prescribers determine that dose reduction is required for safety despite patient reluctance, they should explain the rationale clearly and act in the person's best interests. The patient information leaflet on planned reduction for safety reasons can be used (Appendix 4b) to support these discussions. This leaflet provides a more directive explanation of the rationale for deprescribing, outlining the expected benefits of reduction, how withdrawal symptoms will be managed, and the support

that will be offered. Where it is deemed necessary, use of a Record of agreement (Appendix 4c) can also be considered.

4.9 Discontinuation in people with dependence or ongoing reluctance

People who are dependent, at higher risk, or reluctant to reduce their gabapentinoid dose may need a slower plan with more support and closer follow-up.

Key principles:

- **Use a slower, individual taper:** Smaller dose reductions and longer intervals are often needed to minimise withdrawal symptoms.
- **Review benefits and risks regularly:** Revisit treatment goals and discuss the risks of long-term use at each stage.
- **Monitor closely:** Regular contact helps identify withdrawal symptoms or concerns early.
- **Encourage non-drug approaches:** Discuss self-management strategies and non-pharmacological support to help manage symptoms during reduction.
- **Offer reassurance:** Dose reduction can be slowed or paused if symptoms become difficult to manage.

If the person does not engage or attend reviews

- **Make reasonable attempts to contact the person**, including telephone calls and written communication.
- **Use written communication to clearly explain the need for review**, the reasons for dose reduction, and the proposed dose reduction plan.
- **Consider planned dose reduction** where it is in the person's best interests.
- **Record all contact attempts, decisions, and the agreed plan** in the clinical record so that other colleagues can see the plan.

Special circumstances:

People taking doses above the recommended maximum, or those with a history of substance use, severe medical or psychiatric illness, or previous withdrawal seizures, may require specialist advice. Where specialist or substance use services are available and appropriate, referral should be considered. In areas where such services are limited or do not accept referrals for prescribed medicines, management should be planned carefully within available local resources.

4.10 Documentation at discontinuation

- Decision to reduce or stop the medicine, made in the person's best interest.
- The rationale behind this decision, such as lack of benefit, adverse effects, or safety concerns.
- Agreed outcomes of gabapentinoid tapering (e.g. complete cessation or reduction to a lower effective dose).
- Agreed tapering schedule (with dates and dosage steps).
- Monitoring and support plans during dose reduction.
- Follow-up dates for scheduled reviews.
- Educational resources provided to the person (e.g. information leaflets, contact details for support groups).

Appendix 4a: Patient information leaflet – Reducing your gabapentin or pregabalin for pain

This leaflet explains why reducing your dose of gabapentin or pregabalin may be right for you, and what might happen if your dose is reduced. Your medicine is sometimes used for long-lasting (chronic) pain. However, it may not work for some people and may cause unwanted effects (side effects).

Why reduce my dose?

Your healthcare worker may recommend reducing your dose of gabapentin or pregabalin if:

- you are experiencing side effects
- your pain has not improved despite treatment
- you wish to take fewer medicines
- the medicine is no longer helping your day-to-day activities
- this medicine is unlikely to help with your type of pain
- continuing treatment may put you at risk of harm.

How will my dose be reduced?

Your dose will be reduced slowly, and the speed of reduction will depend on:

- how much you are currently taking
- how long you have been taking it
- how your body responds to each change.

Follow the plan that you have agreed with your healthcare worker.

Do not stop taking this medicine suddenly unless you have been advised to do so.

How might I feel when reducing my dose?

Some people experience symptoms when their dose of gabapentin or pregabalin is reduced. Symptoms might include:

- anxiety, disturbed sleep, dizziness, or headaches
- feeling sick (nausea), diarrhoea, or sweating
- generalised aches and pains.

These are known as ‘withdrawal symptoms’ and are usually short-lived and get better over time. If you find these symptoms are difficult to manage, ask your healthcare worker for advice and support.

What if my pain increases?

Some people notice that their pain gets worse for a short time when their dose is reduced. You should ask your healthcare worker for advice before making any changes.

Your healthcare worker may:

- slow the reduction plan
- keep the dose the same for longer
- suggest other ways to manage your pain.

Do not increase your dose yourself. Taking a higher dose than prescribed can be dangerous and increases the risk of serious side effects or overdose.

Who will support me while I am reducing my dose?

Your healthcare worker will guide you through reducing your dose and make sure all changes are made safely. To help you manage during your dose reduction:

- You and your healthcare worker will agree a clear plan before starting any changes to your dose.
- Your local (community) pharmacist can advise and support you.
- The pace of reduction can be slowed, if needed.
- If you have any concerns, or if your symptoms are difficult to manage, tell your healthcare worker.
- What if I feel worried?

It is common to feel anxious when asked to change a medicine that you have taken for a long time. Living with long-lasting pain is difficult. The aim of dose reduction is to keep you safe and to make sure that any medicine you take is doing you more good than harm.

You can help by:

- keeping a simple diary of pain, sleep and symptoms
- attending review appointments
- raising concerns early
- using other ways of managing pain such as staying active, taking gentle exercise and having a healthy lifestyle. Your healthcare worker can suggest some options that might be suitable for you.

If you have any concerns, contact your healthcare worker.

Visit the AWTTC website for useful links and resources.

Your dose reduction plan

Take the capsules as shown in the table below. Start at the dose you are currently taking.

Date or week of change	Morning dose	Midday dose	Evening dose

Do not reduce your gabapentin or pregabalin dose faster than once a week unless you are advised to do so by your healthcare worker, and they are monitoring your dose reduction.

Reducing your dose too quickly might make you feel unwell. If you notice any new or worsening symptoms after reducing your dose, ask your healthcare worker for advice.

- Changes to your dose can be made weekly, fortnightly, or monthly.
- Agree your changes with your healthcare worker.
- If you want to go faster or slower with the reductions, ask your healthcare worker so that they can support you.
- Any dose reduction is likely to be good for your general health and wellbeing if it is done gradually.

If you want to have a break from reducing the dose, then ask your healthcare worker if you can start reducing the dose again after a few weeks.

Appendix 4b: Patient information leaflet – Reducing your gabapentin or pregabalin for safety reasons

This leaflet explains why your healthcare worker is reducing or stopping gabapentin or pregabalin, what will happen during this process, and how you will be supported. It is for people who have been taking one of these medicines for long-lasting (chronic) pain.

Why is my medicine being reduced?

Your healthcare worker reviews your medicine regularly to make sure that it is safe and helpful.

Research shows that gabapentin and pregabalin only help a small number of people with long-lasting pain.

These medicines are not usually recommended for conditions such as fibromyalgia (long-lasting pain in many parts of the body); lower back pain with or without or sciatica (pain that travels from the lower back down the leg). This is because they are unlikely to give enough benefit and may cause unwanted effects (side effects).

Your healthcare worker has carefully considered your situation and believes that continuing this medicine is not the safest option for you.

What are the risks of long-term use?

Taking gabapentin or pregabalin for a long time can increase the risk of:

- breathing difficulties (such as breathing becoming slow or feeling unable to get enough air)
- problems with memory or concentration
- becoming physically dependent on the medicine.

The risks are higher if you also take other medicines that can make you drowsy, such as strong painkillers, sleeping tablets or anxiety medicines.

Some people are more vulnerable because of their age, other health conditions, kidney problems, or other medicines they take.

Your healthcare worker has considered these risks when recommending that this medicine is reduced.

What are the benefits of reducing gabapentin or pregabalin?

Reducing or stopping this medicine can reduce the risk of harm. Some people notice improved alertness, memory or concentration. Others find that their overall function, energy or quality of life improves as side effects reduce.

What will happen next?

Your healthcare worker will arrange a slow and carefully planned reduction in your dose.

Before any changes are made, you will be given clear information about what dose changes are planned and when they will happen, and you will have a chance to ask questions.

During the process your healthcare worker will monitor your symptoms, pain levels and general wellbeing.

Why do I need to attend appointments and stay in contact?

You need to attend your appointments so your healthcare worker can check how you are getting on and reduce your dose safely.

If you are unable to attend an appointment, please let your healthcare team know so another arrangement can be made.

What symptoms might I notice while the medicine is being reduced?

Some people notice withdrawal symptoms, particularly if they have been taking this medicine for a long time. These symptoms can include:

- feeling anxious or unsettled
- difficulty sleeping
- feeling sick
- sweating
- shaky or flu-like feelings.

These symptoms can be unpleasant but are common and usually improve when the dose is reduced slowly. They may begin within a day and often settle within a week. If you notice these symptoms:

- do not reduce the dose any further
- stay on the current dose
- wait until the symptoms settle before the next reduction.

If the withdrawal symptoms continue, worsen, or become hard to cope with, ask your healthcare worker for advice and support.

What if I am not happy about this change?

The plan to reduce this medicine is about preventing harm and finding safer ways to manage your pain.

However, being asked to stop or reduce a medicine that you have taken for a long time may feel frustrating or difficult, especially when you are already dealing with long-lasting pain or other health problems.

Tell your healthcare worker how you are feeling, so that they can hear your concerns and fully explain the reasons for the change. They can also arrange extra support for you.

What else can help my pain?

Medicines are only one part of managing long-lasting pain.

Depending on what is available where you live, you may be offered:

- physiotherapy or gentle exercise programmes
- advice about pacing, which means planning activities and rest, so you do not overdo things and trigger flare-ups
- psychological support or pain-management support to help you cope with symptoms and stress
- community services such as local wellbeing groups or support programmes.

These approaches aim to help you cope better day-to-day and to improve your quality of life. Visit the AWTTC website for useful links and resources.

How will my healthcare worker support me?

We want to keep you safe, reduce the risk of harm, and support you while this medicine is being reduced.

Your healthcare worker will:

- explain decisions clearly
- listen to your concerns
- monitor symptoms carefully
- adjust plans if needed
- help you find safer ways to manage pain.

Appendix 4c: Record of agreement – Planned gabapentin or pregabalin reduction

This document records the agreed plan to reduce gabapentin or pregabalin for safety reasons and the support provided during this process.

Patient name: …… NHS number: ……

Drug name (select): gabapentin or pregabalin.

Condition being treated: …….

Record of agreement

By signing this document, I confirm that:

1. I understand why dose reduction is recommended and have been given information about reducing this medicine.

2. I understand that I may experience withdrawal symptoms, and I know who I should contact if I struggle. My healthcare worker has explained that my dose will be reduced gradually, with review and support, and that the pace can be adjusted if needed.

3. I agree to follow the dose reduction plan and will not obtain gabapentin or pregabalin from any other source.

4. I understand that prescriptions will be issued in line with the agreed plan and that early or replacement prescriptions may not always be possible.

6. I understand that taking more medicine than prescribed, obtaining medicine elsewhere, repeatedly losing prescriptions, or not following the agreed plan will prompt a review and may result in further reduction or stopping my medicine.

7. I am responsible for keeping my medicine safe at home. I understand that sharing my medicine is illegal and dangerous.

8. I understand that my treatment will be regularly reviewed, and my dose may be further reduced if safety concerns arise or if I do not follow the agreed plan.

Patient signature: ……Date: ……

Resource pack 5: Auditing gabapentinoid prescribing and supporting tools

5.0 Auditing gabapentinoid prescribing and supporting tools

Audit tools are provided to support safe and appropriate prescribing practices. These include adaptable templates, letters and patient-facing messages to facilitate both routine medication reviews and targeted audits, such as those for people at higher risk or with renal impairment.

- Appendix 5a: Audit template – General review of gabapentin and pregabalin prescribing
- Appendix 5b: Example letter – Invitation for general gabapentinoid review
- Appendix 5c: Example text message – Invitation for general gabapentinoid review
- Appendix 5d: Audit template – Gabapentin and pregabalin prescribing in adults with renal impairment
- Appendix 5e: Example letter – Invitation to review (high dose/renal function)
- Appendix 5f: Example letter – Invitation to review (co-prescribed gabapentin or pregabalin with an opioid, benzodiazepine or Z-drug)
- Appendix 5g: Social media – patient messages designed to help raise awareness among patients of the need for review.

Appendix 5a: Audit template – General review of gabapentin and pregabalin prescribing

Background

Gabapentinoids (gabapentin and pregabalin) are widely prescribed for a range of indications. While they may provide benefit for some people, prescribing is often continued long term despite limited evidence for sustained effectiveness. Both medicines are associated with recognised risks, including adverse effects, dependence, and misuse.

Objective

To assess the appropriateness, safety, and adherence of gabapentin and pregabalin prescribing in adults.

Inclusion

- Adults (≥ 18 years) prescribed gabapentin or pregabalin for any indication.

Exclusion

- Under 18 years
- People with epilepsy

Audit period

Previous 6 months of prescribing activity

Scope

This audit involves evaluating indications for prescribing, duration of use, safety, monitoring, co-prescribing of opioids/CNS depressants and patient adherence.

Audit methodology

1. Identify all adults prescribed gabapentin or pregabalin (including branded products) within the past six months.
2. For each person, extract the information in Section 1 from the medical record:
    - Treatment details (medication, dose, start date, and duration).
    - Indication and prescribing source (recorded indication and initiating prescriber, any previous trial, and any non-pharmacological measures).
    - Safety considerations (most recent renal function (CrCl/eGFR), whether the dose is appropriate for renal status, whether any opioids or other CNS depressants are co-prescribed, and whether a dose reduction has been attempted).
    - Monitoring information by recording the date of the last review and any indication of functional improvement or overall benefit; a review may be taken from a medication review entry, annual review, or any clinical note where ongoing treatment is considered.
    - Assess adherence by reviewing ordering patterns and any clinician comments, classifying people as adherent, non-adherent, or unable to determine where documentation is insufficient.
    - Record planned next steps (continue/reduce/ stop/unclear)
3. Record findings for each selected person using Section 1: Patient data collection table, available below or as an Excel template [URL to be included].
4. Summarise data using Section 2: Summary table.
5. Reflect on results and document lessons learned, planned activities, and agreed changes in Section 3: Review and action plan.
6. If possible, please consider sharing your audit findings with AWTTC.

Section 1: Patient data collection table (an Excel template is also available [URL to be included])

A. Patient and treatment details			
Patient ID	**Medication (name/strength)**	**Current daily dose (mg)**	**Duration on treatment**
B. Indication and prescribing source			
Indication	**Initiating prescriber (GP/Mental health/Pain/Hosp)**	**Previous trial of neuropathic agent (Yes/No)**	**Non-pharmacological measures**
C. Safety considerations			
Renal function (CrCl/eGFR)	**Dose appropriate for renal function (Yes/No)**	**Co-prescribed opioids/CNS depressants (Yes/No)**	**Reduction attempted? (Yes/No)**
D. Monitoring and adherence			
Date of last review	**Functional improvement/ benefit (Yes/No/unclear)**	**Adherence (adherent /non-adherent/unable to determine)**	**Plan recorded (continue/reduce/ stop/unclear)**

Section 2: Summary table

Metric	Number of patients	Percentage (%)
Total patients reviewed		
Indication: Neuropathic pain		
Indication: Other		
Prescribing initiated by GP		
Prescribing initiated by Mental Health Team		
Prescribing initiated by Pain Clinic		
Prescribing initiated during hospital admission		
Trial of neuropathic agent documented		
Dose adjusted for renal function		
Co-prescribed with opioids or CNS depressants		
Functional improvement/benefit reviewed		
Adherent to prescribed regimen		

Section 3: Review and action plan

3.1 Lessons learned

What did the practice learn from carrying out this audit?

3.2 Planned activities

Tick and describe activities the practice intends to undertake as a result of this audit:

- Review people co-prescribed opioids or CNS depressants ☐
- Review long-term therapy with unclear ongoing benefit ☐
- Standardise prescribing and review protocols ☐
- Provide clinical education to prescribers ☐

Details of planned activities:

3.3 Agreed changes

What specific changes will be made in response to the audit findings?

Appendix 5b: Example letter – Invitation for general gabapentinoid review

[Title/Initial/Surname]

[Patient Address Block]

Dear [Title] [Surname]

The Surgery are carrying out a review of all our patients' prescriptions for gabapentin and pregabalin. We are doing this in response to recent medical research that has looked at the long-term benefits and risks of these medicines.

Your medical records show that you are taking one of these medications for pain. We know that for some people they can be helpful, but also that they can sometimes be addictive and cause significant side effects.

Many people start taking these medications because they have pain that is difficult to manage and may continue to take them even though they are not helping very much. Sometimes people find them helpful when they start but continue to take them even though they are no longer working as well, or for some people the reason they started them has gone away but the medication has not been reduced or stopped. We are very keen to help support people who would like to reduce their dose, or stop these medications, or to look at alternative ways of managing their pain.

We have made sure that there are telephone appointments available with the practice pharmacists for you and other people in your position. Please contact the surgery and ask for a 'gabapentin or pregabalin review' to discuss this further.

You may also benefit from the information about pain management on www.paintoolkit.org/ or www.livewellwithpain.co.uk or the online Education Programmes for Patients available via EPP Cymru

Yours sincerely

XXXXXX

Appendix 5c: Example text message – Invitation for general gabapentinoid review

Dear [insert patient name]

We are conducting a review of all our patients' prescriptions for gabapentin/pregabalin (delete as appropriate) This is to assess the long-term benefits and risks of this medication for you.

Please contact the surgery and ask for a 'gabapentin or pregabalin review' to discuss this further.

You may also find the following pain management resources helpful: www.paintoolkit.org/ or www.livewellwithpain.co.uk or the online Education Programmes for Patients available via EPP Cymru

Thank you [Enter practice name]

Appendix 5d: Audit template – Gabapentin and pregabalin prescribing in adults with renal impairment

Background

Gabapentin and pregabalin are eliminated almost entirely by the kidneys. Impaired renal function leads to higher plasma concentrations and prolonged elimination, increasing the risk of adverse effects such as dizziness, drowsiness, cognitive impairment, headache, blurred vision, and hallucinations. This audit aims to ensure that doses of gabapentin and pregabalin are prescribed appropriately according to renal function, in line with the SmPC, AWMSG, and local guidance.

Aim

To ensure that the dose of gabapentin or pregabalin prescribed in adults is appropriate for the degree of their renal function as per SmPC.

Inclusion

- Adults (≥ 18 years) prescribed gabapentin with eGFR < 80 ml/min/1.73m²
- Adults (≥ 18 years) prescribed pregabalin with eGFR < 60 ml/min/1.73m²

Exclusion

- Under 18 years
- People with epilepsy

Method

- Run a search to identify people who are currently receiving prescriptions for gabapentin with an eGFR < 80 ml/min/1.73m^2.
- Run a search to identify people who are currently receiving prescriptions for pregabalin with an eGFR < 60 ml/min/1.73m^2.
- Ensure U&Es (within 12 months, or 3–6 months if acute kidney injury [AKI]/unstable) and weight (within 12 months) are up to date.
- Calculate CrCl.
- Complete the data collection form (Section 1) with patient details, monitoring, and dosing assessment, available below or as an Excel template [URL to be included].
- Compare current doses with the recommended maximums (see Reference tables).
- Record any discrepancies, agree changes with the GP, and document outcomes.
- Summarise data using Section 2: Summary table.
- Reflect on results and document lessons learned and agreed changes in Section 3: Review and action plan.
- If possible, please consider sharing your audit findings with AWTTC.

Dose adjustment

For renal dose adjustments see section 2.7.1.

Section 1: Patient data collection table (an Excel template is also available [URL to be included])

(Excel data collection templates will be developed to accompany this section.)

A. Patient and treatment details				
Patient ID	**Medication (name/strength)**	**Current daily dose (mg)**	**Indication**	**Duration on treatment**
B. Clinical information				
Date of last U&Es	**Date of last weight**	**CrCl (ml/min)**	**Max recommended daily dose for CrCl**	
C. Dose review				
Dose appropriate for renal function? (Yes/No)	**If not, recommended adjusted dose**	**Reduction attempted? (Yes/No)**	**Additional comments (optional)**	

Section 2: Summary table

Metric	Number of patients	Percentage (%)
Total patients reviewed		
U&Es up to date (≤ 12 months/≤ 6 months if unstable)		
Weight up to date (≤ 12 months)		
CrCl documented		
Current dose appropriate for renal function		
Dose reduction required		

Section 3: Review and action plan

3.1 Lessons learned

What did the practice learn from carrying out this audit?

3.2 Agreed changes

What specific changes will be made in response to the audit findings?

3.3 Maintaining the changes

How will these changes be maintained?

Appendix 5e: Example letter – Invitation to review (high dose/renal function)

[Title/Initial/Surname]

[Patient Address Block]

Dear [Title] [Surname]

We are reviewing people who take gabapentin or pregabalin to check that their dose is still right for them.

Recent evidence has highlighted safety concerns at higher doses and in certain clinical situations, including reduced kidney function. Our records show that you are currently prescribed one of these medicines at a dose that may require review.

We would like to discuss your medication with you before your next prescription is due to make sure it is safe and appropriate for you. You should continue taking your medication as prescribed until we have spoken with you.

Please contact the surgery to arrange a telephone appointment for a gabapentin or pregabalin review.

You may also find the following pain management resources helpful: www.paintoolkit.org/ or www.livewellwithpain.co.uk or the online Education Programmes for Patients available via EPP Cymru

Yours sincerely

XXXXXX

Appendix 5f: Example letter – Invitation to review (co-prescribed gabapentin or pregabalin with an opioid, benzodiazepine or Z-drug)

[Title/Initial/Surname]

[Patient Address Block]

Dear [Title] [Surname]

We are reviewing people who take gabapentin or pregabalin to make sure their medicines are safe and still right for them.

Our records show that you are taking gabapentin or pregabalin together with an opioid (a strong painkiller), a benzodiazepine (often used for anxiety), or a sleeping tablet known as a Z-drug. Taking these medicines together can increase the chance of side effects, so we would like to review your treatment.

This does not mean you need to stop any of your medicines. Please continue taking them as prescribed until we have spoken with you.

Please contact the surgery to arrange a telephone appointment for a gabapentin or pregabalin review.

You may also find the following pain management resources helpful: www.paintoolkit.org/ or www.livewellwithpain.co.uk or the online Education Programmes for Patients available via EPP Cymru

Yours sincerely

XXXXXX

Appendix 5g: Social media – Patient messages

These example posts are designed for use on social media channels such as X, Facebook or LinkedIn. Health boards can adapt them for local use.

Post 1 – Not seeing improvement? Time for a review

Taking gabapentin or pregabalin?
If it's not clearly helping your day-to-day life, it may be time for a review. Regular checks help make sure your medicine is still right for you.
➡️ Ask your GP practice if you're due a review. #SaferMedicines #YourMedicineYourHealth

Post 2 – Medicines aren't the only answer

Medicines are just one part of managing pain. Things like keeping active, sleeping well, and taking things at your own pace can help too.
➡️ Speak to your GP or pharmacist about support options. #LiveWellWithPain

Post 3 – Side effects getting in the way?

Feeling sleepy, dizzy or unsteady on gabapentin or pregabalin? Side effects can affect your safety and daily life – don't ignore them.
➡️ Talk to your GP or pharmacist for advice. #SaferMedicines #YourMedicineYourHealth

Post 4 – When your medicine isn't helping

If your medicine isn't helping you do the things that matter, it may not be the right option anymore. There may be safer or more effective ways to manage your pain.
➡️ Speak to your GP or pharmacist. #PainManagement #SaferMedicines

Post 5 – Taking other strong painkillers too?

Taking gabapentin or pregabalin with medicines like codeine, tramadol or morphine can make you sleepy and can slow your breathing.
If you're taking these together, it's important to get them checked.
➡️ Speak to your GP or pharmacist. #MedicationSafety #YourHealthMatters

Post 6 – Thinking about cutting down?

Some people choose to reduce or stop their medicine if it's not helping. This should be done slowly and with support.
➡️ Speak to your GP or pharmacist before making changes. #PainSupport #SaferMedicines

6.0 Frequently asked questions

"Who is most at risk from gabapentinoids?"

Potentially, anyone using gabapentin or pregabalin is at risk of adverse effects and dependence. Dependence, in most cases, is a physiological phenomenon that is observed with many medicines. The issue with gabapentinoids is that dependence can become problematic and people can find themselves craving the medicine or taking more than prescribed due to the dissociative effects it provides. Every person prescribed a gabapentinoid should therefore be considered susceptible to problems of dependence.

There are other risks associated with gabapentinoids. Combination with opioids, benzodiazepines, Z-drugs or other CNS depressants increases sedation, cognitive impairment and the risk of toxicity which includes respiratory impairment.

"Can you use eGFR for adjusting gabapentinoid doses or should it be CrCl?"

Use of eGFR is acceptable to guide dosing, especially when the information needed for CrCl is not available. Given the poor effectiveness of gabapentinoids for the majority of people and the associated risks, being overly cautious in terms of dosing is very unlikely to be harmful.

However, if someone requires a significant reduction such as 50%, due to an acute or chronic change in their renal function, consider a rapid taper e.g. reduce one of the two or three daily doses every 2–3 days, unless their health is considered to be at immediate risk.

"How can we increase awareness of adverse effects as a way of encouraging people who are concerned to reduce gabapentinoids?"

When carrying out a medication review, it is often easier to ask people about problems they are experiencing and then link them back to the medicines they take, rather than asking 'What side effects do you have?' Especially with long-term medicines use, people will often not recognise issues as being related to their medication, perhaps assuming it is just another problem they've developed. Examples with gabapentinoids include a person noting they have put on weight or are finding it hard to lose weight – weight gain and over-eating are known adverse effects of gabapentinoids which the person might not be aware of. Should they reduce their dose, they are likely to find it easier to lose some weight, this may have a knock-on effect on their general health and well-being. Similarly, someone might be concerned that the memory problems they are experiencing are 'Alzheimer's' when they could be partly associated with gabapentinoid use.

Similarly, people with known respiratory problems such as COPD or sleep apnoea are at increased risk of respiratory impairment especially when using gabapentinoids with opioid medicines. Whilst it may seem cruel to tell people that they could die from taking prescribed medicines, it is absolutely necessary that people are fully informed of the risks of the medicines they take.

We obviously do not always know for certain whether the issue is purely due to the medicine or to an underlying condition, but making the link e.g. 'gabapentin could be making that problem harder to manage' or 'continuing this high dose of pregabalin might make it harder to be certain about a diagnosis' can give people a focus for change. Most people are not aware of the myriad side-effects of their medicines and so supporting them to make these links is important. They might say it is the first time they had been told about the issue and be quite keen to make a reduction after finding out.

"Can you build up tolerance to gabapentinoids?"

This is a tricky one to answer. In theory, tolerance is possible with most medicines and gabapentinoids are no different. However, most medicines used in pain management are also poorly effective, especially with prolonged use. Reports of reducing effect over time being partially mitigated by an increase in dose might be due to the increased dose causing side-effects, such as sedation or dissociation, which give a short-term 'benefit'. Predominantly, it removes the person from the symptoms rather than removing the symptoms from the person. This imitates the classic model of tolerance.

It is reasonable under these circumstances to assume that poor effect, wearing off or however the person explains it, is a sign that the medicine is no longer helpful. Whether this is tolerance or not, is less important perhaps than the issue of poor effect. However, people often want an explanation for why something they think did work is no longer working for them. The best explanation is the one that makes sense to the person. As we are unable to be definitive, then explaining tolerance or explaining that the medicine simply no longer offers benefit are both acceptable.

"Lots of people are prescribed gabapentinoids for sciatica but it is not in the NICE or All Wales guidelines now. What should we do with those people?"

More recent studies and trials have demonstrated gabapentinoids are no better than placebo for managing symptoms of sciatica. For some people, due to the adverse effects, the medicines can make mobilising and increasing function more difficult. If people have been prescribed gabapentinoids for more than 3 months for sciatica (radicular) – type pain in their back and legs, then they should be offered a review. If they are not able to demonstrate functional improvement in addition to symptom reduction, they should be encouraged to slowly reduce and stop the gabapentinoid. If they are benefiting from the medicine e.g. improving or maintained function, enabling work, activity etc., then it can continue. The person should still be given information about the risks of the medication. Regularly review every six months to a year should be undertaken and the medicine withdrawn as and when it no longer provides benefit. As with all types of pain, people should be provided with information about the underlying condition, self-management and other groups or services which can be accessed to support them rather than just relying on the medicines.

"Why is pregabalin associated with higher rates of misuse than gabapentin?"

Pregabalin was designed to have faster absorption and higher bioavailability than gabapentin, resulting in effectively a more rapid onset of effect. This is helpful for its intended clinical purpose, where people might start feeling some benefit from the medicine within 1–2 weeks. However, it also means that the dissociative effects, which people who are misusing it are generally seeking, also occur more rapidly, especially when the dose is high. Unlike pregabalin, gabapentin plateaus in dose-response effect. This means that at a certain dose, thought to be around 2400–3600 mg, the increase in effect is very limited with any further dose escalation. Pregabalin has a straight dose-response curve which in theory means that an increase in dose should always produce an increase in effect. Whilst this is not the case clinically in relation to neuropathic pain, it is likely to have an effect when the medicine is subject to misuse.

"Is memory loss a known problem with gabapentinoids?"

In short, yes. Problems of cognition and memory are known adverse effects with both gabapentin and pregabalin. It does not appear to be entirely due to dose, so people may experience it even with low doses. Older people are more susceptible to these effects, due to changes in blood–brain barrier permeability, although anyone may report it. If people are concerned about problems they're experiencing, then reducing the dose and, ideally, stopping the drug is very likely to lead to noticeable improvements in mental clarity. Even people with cognitive decline e.g. early dementia, can benefit from reducing and stopping gabapentinoids and other medicines that may be affecting them e.g. opioids.

"Pregabalin was started for anxiety, but the person also has pain, can it be reviewed?"

Pregabalin is an option for generalised anxiety disorder within the NICE guidelines, where SSRIs or SNRIs cannot be tolerated. Consequently, if the person has been started on pregabalin by their mental health professional then it should follow that their antidepressant is withdrawn as pregabalin is titrated. Pregabalin is also included by NICE and AWMSG in the *All Wales pharmacological management of pain guidance* prescribing guidelines for neuropathic pain. In those cases, it may be co-prescribed with an antidepressant if the antidepressant was helpful for the person – either for their mood or pain.

Regardless of the indication, however, if pregabalin is not benefiting the person in respect to their symptoms, if they have signs of harm or if they have additional factors which increase their risk (e.g. co-prescription of opioids, benzodiazepines, Z-drugs or other CNS depressants) then its continued use must be reviewed.

If someone is under the care of psychiatry or pregabalin was started by them prior to discharge from the service, the original prescriber should be informed of the harm being caused and advice sought on alternative management. If the person is considered to be at risk from the adverse effects of pregabalin or a combination of it and their other medicines, then a careful reduction should start even whilst awaiting additional guidance.

7.0 Useful patient resources

The Pain Toolkit
Self-management support devised by Pete Moore, who himself lives with persistent pain. Includes a long list of links to a variety of charities and support for long-term conditions: www.paintoolkit.org.

Live Well with Pain
Supported self-management resources developed by people living with pain and professionals working with them: www.livewellwithpain.co.uk. Includes links to the Ten Footsteps – can be used to support education programmes for patients or as an alternative for people who feel able to work through things on their own or with a little support from their healthcare team.

- Ten Footsteps to Living Well with Pain.
- Ten Footsteps for carers.

Health Education Improvement Wales – Analgesic Stewardship and Pain Management
Information to support healthcare professionals in their interactions with people living with pain. It can often be complex and challenging therefore this page shares information on the key themes of current guidance and useful resources for analgesic stewardship and pain management: Analgesic Stewardship and Pain Management.

Pain Concern
Pain Concern is a charity based in Scotland which provides information for people living with pain, their carers and healthcare professionals: https://painconcern.org.uk. They have a regular podcast, Airing Pain, which highlights various areas of pain management as well as getting experts (professional and lived experience) to talk about topics of interest and new developments in research. The Self-Management Navigator Tool can help people get the most out of discussions about their pain at appointments with healthcare professionals.

Living Well with Pain
A website created by Tina, who lives with persistent back pain and sciatica. Provides information about sciatica and methods of managing and living better with it. Tina also shares her experience of navigating healthcare services and communicating with professionals about her condition which can be helpful for other people to learn from: https://livingwellpain.net.

Chronic pain resources from healthtalk.org
A repository of videos of people talking about living with a range of different health conditions, including a section on Chronic pain. Living with pain can be an isolating experience and sharing experiences can help people feel less alone and give insight into different approaches which others have found helpful (or not).

Flippin' Pain
Flippin' Pain's mission is to raise awareness of the science of pain and change the way we think about, talk about, and treat persistent pain. The team provides webinars that can be accessed by people with pain and healthcare professionals as well as live events featuring experts from all over the world: https://flippinpain.co.uk.

Pain Revolution
The Flippin Pain work is based on that of Pain Revolution in Australia: www.painrevolution.org/. They have a short film called Tame the Beast, which explains persistent pain mechanisms.

EPP Cymru
Patients can self-refer to the Education Programmes for Patients for chronic pain: https://performanceandimprovement.nhs.wales/functions/quality-safety-and-improvement/improvement/our-work/epp/

British Pain Society
The British Pain Society is a multi-disciplinary organisation that promotes best practice and research in pain. They have a section on their website for people living with pain with links to British Pain Society information and external resources: www.britishpainsociety.org/people-with-pain/.

Faculty of Pain Medicine
The Faculty of Pain Medicine provides patient information leaflets on pain medicines accessible via a QR code.

Retrain Pain
Free online course for people living with pain. Designed to aid understanding and start on the path to self-management: www.retrainpain.org/.

NHS Online Studio
A range of videos are available to help and encourage people to move, including Tai Chi and yoga-based exercises: www.nhs.uk/conditions/nhs-fitness-studio/.

Short films for people with pain:
- How does your brain respond to pain?
- Pain and me
- Understanding pain in less than 5 minutes
- Why things hurt

Useful books:
- An Introduction to Living Well with Pain – Frances Cole ISBN-10:147213771X
- Manage Your Pain – Michael Nicholas, Alan Molloy, Lois Tonkin, and Lee Beeston ISBN: 0-75380-9974
- The Pain-free Mindset – Deepak Ravindran ISBN: 978-1-78504-339-0

8.0 References

1. British National Formulary. Gabapentin. 2025. Available at: https://bnf.nice.org.uk/drugs/gabapentin/. Accessed August 2025.
2. Electronic Medicines Compendium. SPC: Gabapentin 300mg capsules. 2019. Available at: https://www.medicines.org.uk/emc/product/2361/smpc. Accessed May 2025.
3. British National Formulary. Pregabalin. 2025. Available at: https://bnf.nice.org.uk/drugs/pregabalin/. Accessed August 2025.
4. Electronic Medicines Compendium. SPC: Pregabalin 150mg Capsules. 2017. Available at: https://www.medicines.org.uk/emc/medicine/30924. Accessed May 2025.
5. Electronic Medicines Compendium. SPC: Gabapentin 100mg capsules. 2019. Available at: https://www.medicines.org.uk/emc/medicine/26529. Accessed May 2025.
6. National Institute for Health and Care Excellence. Generalised anxiety disorder and panic disorder in adults: management. 2011. Available at: https://www.nice.org.uk/guidance/cg113.
7. Ashworth J, Bajpai R, Muller S et al. Trends in gabapentinoid prescribing in UK primary care using the Clinical Practice Research Datalink: an observational study. *The Lancet Regional Health - Europe.* 2023;27(no pagination). Available at: https://www.thelancet.com/journals/lanepe/article/PIIS2666-7762(22)00275-7/fulltext.
8. Schaffer AL, Busingye D, Chidwick K et al. Pregabalin prescribing patterns in Australian general practice, 2012-2018: a cross-sectional study. *BJGP Open.* 2021;5(1):1–10. Available at: https://pubmed.ncbi.nlm.nih.gov/33172853/.
9. Goodman CW, and Brett AS. A Clinical Overview of Off-label Use of Gabapentinoid Drugs. *JAMA Internal Medicine.* 2019;179(5):695–701. Available at: https://doi.org/10.1001/jamainternmed.2019.0086.
10. Montastruc F, Loo SY, and Renoux C. Trends in First Gabapentin and Pregabalin Prescriptions in Primary Care in the United Kingdom, 1993-2017. *JAMA.* 2018;320(20):2149–2151. Available at: https://doi.org/10.1001/jama.2018.12358. Accessed 2/10/2025.
11. National Institute for Health and Care Excellence. Low back pain and sciatica in over 16s: assessment and management (NG59). 2016. Available at: https://www.nice.org.uk/guidance/ng59. Accessed November 2025.
12. Enke O, New HA, New CH et al. Anticonvulsants in the treatment of low back pain and lumbar radicular pain: a systematic review and meta-analysis. *Cmaj.* 2018;190(26):E786–e793.
13. Giménez-Campos MS, Pimenta-Fermisson-Ramos P, Díaz-Cambronero JI et al. A systematic review and meta-analysis of the effectiveness and adverse events of gabapentin and pregabalin for sciatica pain. *Aten Primaria.* 2022;54(1):102144.
14. Medicines and Healthcare products Regulatory Agency. Pregabalin (Lyrica), gabapentin (Neurontin) and risk of abuse and dependence: new scheduling requirements from 1 April. 2019. Available at: https://www.gov.uk/drug-safety-update/pregabalin-lyrica-gabapentin-neurontin-and-risk-of-abuse-and-dependence-new-scheduling-requirements-from-1-april. Accessed February 2025.
15. Medicines and Healthcare products Regulatory Agency. Pregabalin (Lyrica): reports of severe respiratory depression. 2021. Available at:

https://www.gov.uk/drug-safety-update/pregabalin-lyrica-reports-of-severe-respiratory-depression. Accessed February 2025.
16. Medicines and Healthcare products Regulatory Agency. Gabapentin (Neurontin): risk of severe respiratory depression. 2017. Available at: https://www.gov.uk/drug-safety-update/gabapentin-neurontin-risk-of-severe-respiratory-depression. Accessed February 2025.
17. Medicines and Healthcare products Regulatory Agency. Improving Information Supplied with Gabapentinoids (Pregabalin/Gabapentin), Benzodiazepines and Z-Drugs. 2026. Available at: https://www.gov.uk/drug-safety-update/improving-information-supplied-with-gabapentinoids-pregabalin-slash-gabapentin-benzodiazepines-and-z-drugs?utm_source=Royal%20Pharmaceutical%20Society&utm_medium=email&utm_campaign=15319073_Drug%20Safety%20Update%3A%20Improving%20Information%20Supplied%20with%20Gabapentinoids%20%28Pregabalin%2FGabapentin%29%2C%20Benzodiazepines%20and%20Z-Drugs&utm_content=gov.uk%202&dm_i=EQ,94C9T,6137M4,126V9J,1. Accessed January 2026.
18. Oh G, Moga DC, Fardo DW et al. The association of gabapentin initiation and neurocognitive changes in older adults with normal cognition. *Frontiers in Pharmacology.* 2022;13:910719.
19. Hall TD, Shah S, Ng B et al. Changes in mood, depression and suicidal ideation after commencing pregabalin for neuropathic pain. *Aust Fam Physician.* 2014;43(10):705–708.
20. Psychopharmacology Committee of the Royal College of Psychiatrists, and British Association for Psychopharmacology. Gabapentinoids in psychiatric practice: Balancing the risks and benefits. 2025. Available at: https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/position-statements/2025-position-statements/gabapentinoids-in-psychiatric-practice-(ps03-25). Accessed November 2025.
21. Medicines and Healthcare products Regulatory Agency. Pregabalin (Lyrica): findings of safety study on risks during pregnancy. 2022. Available at: https://www.gov.uk/drug-safety-update/pregabalin-lyrica-findings-of-safety-study-on-risks-during-pregnancy. Accessed May 2025.
22. National Institute for Health and Care Excellence. Chronic pain (primary and secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain. 2021. Available at: https://www.nice.org.uk/guidance/ng193/. Accessed February 2025.
23. Office for National Statistics. Deaths related to drug poisoning by selected substances. 2023. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2023registrations#drug-poisonings-from-selected-substances. Accessed February 2025.
24. Electronic Medicines Compendium. SPC: Neurontin 100mg Hard Capsules. 2019. Available at: https://www.medicines.org.uk/emc/product/158. Accessed May 2025.
25. Electronic Medicines Compendium. SPC: Lyrica Capsules. 2019. Available at: https://www.medicines.org.uk/emc/medicine/14651. Accessed May 2025.
26. Electronic Medicines Compendium. SPC: Alzain 100 mg Capsules, Hard. 2019. Available at: https://www.medicines.org.uk/emc/medicine/30054. Accessed May 2025.

27. Kapil V, Green JL, Le Lait MC et al. Misuse of the γ-aminobutyric acid analogues baclofen, gabapentin and pregabalin in the UK. *British Journal of Clinical Pharmacology.* 2014(1365-2125 (Electronic)).
28. Evoy KE, Morrison MD, and Saklad SR. Abuse and Misuse of Pregabalin and Gabapentin. 2017(1179-1950 (Electronic)).
29. Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group. Drug misuse and dependence: UK guidelines on clinical management. 2017. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf. Accessed May 2025.
30. Welsh Government. Welsh Health Circular. Advice for prescribers on the risk of the misuse of pregabalin and gabapentin. 2016. Available at: https://gov.wales/prescribing-guidance-pregabalin-and-gabapentin-whc2016030. Accessed May 2025.
31. Public Health England, and NHS England. Advice for prescribers on the risk of the misuse of pregabalin and gabapentin. 2014. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/385791/PHE-NHS_England_pregabalin_and_gabapentin_advice_Dec_2014.pdf. Accessed May 2025.
32. Advisory Council on the Misuse of Drugs. Pregabalin and Gabapentin advice. 2016. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/491854/ACMD_Advice_-_Pregabalin_and_gabapentin.pdf. Accessed May 2025.
33. Faculty of Pain Medicine. Driving and Pain: Guidance for Faculty of Pain Medicine Members. 2019. Available at: https://www.fpm.ac.uk/sites/fpm/files/documents/2019-07/FPM-Driving-and-Pain-members-information.pdf. Accessed November 2025.
34. UK Government. Drugs and driving: the law. Available at: https://www.gov.uk/drug-driving-law. Accessed November 2025.
35. Driver and Vehicle Licensing Agency. Assessing fitness to drive: a guide for medical professionals. 2016. Available at: https://www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals. Accessed November 2025.
36. Live Well with Pain. Ask yourself six questions. 2025. Available at: https://livewellwithpain.co.uk/resource/ask-yourself-six-questions/. Accessed May 2025.
37. All Wales Medicines Strategy Group. Resources for pharmacological management of pain. 2023. Available at: https://awttc.nhs.wales/medicines-optimisation-and-safety/medicines-optimisation-guidance-resources-and-data/prescribing-guidance/resources-for-pharmacological-management-of-pain/. Accessed November 2025.
38. Soliman N, Moisset X, Ferraro MC et al. Pharmacotherapy and non-invasive neuromodulation for neuropathic pain: a systematic review and meta-analysis. *The Lancet Neurology.* 2025;24(5):413–428. Available at: https://doi.org/10.1016/S1474-4422(25)00068-7. Accessed 2026/01/27.
39. Welsh Government. Living with persistent pain in Wales. 2023. Available at: https://www.gov.wales/people-experiencing-persistent-pain-guidance. Accessed November 2025.
40. Moore RA, Straube S, Wiffen PJ et al. Pregabalin for acute and chronic pain in adults. *Cochrane Database of Systematic Reviews.* 2009(3):Cd007076.

41. Moore RA, Wiffen PJ, Derry S et al. Gabapentin for chronic neuropathic pain and fibromyalgia in adults. *Cochrane Database of Systematic Reviews.* 2014;2014(4):Cd007938.
42. Finnerup NB, Attal N, Haroutounian S et al. Pharmacotherapy for neuropathic pain in adults: a systematic review and meta-analysis. *Lancet Neurol.* 2015;14(2):162–173.
43. National Institute for Health and Care Excellence. Clinical Knowledge Summaries: Neuropathic pain - drug treatment: Gabapentin. 2025. Available at: https://cks.nice.org.uk/topics/neuropathic-pain-drug-treatment/prescribing-information/gabapentin/. Accessed November 2025.
44. National Institute for Health and Care Excellence. Clinical Knowledge Summaries: Neuropathic pain - drug treatment: Pregabalin. 2025. Available at: https://cks.nice.org.uk/topics/neuropathic-pain-drug-treatment/prescribing-information/pregabalin/. Accessed November 2025.
45. General Medical Council. Decision making and consent. 2020. Available at: https://www.gmc-uk.org/professional-standards/the-professional-standards/decision-making-and-consent. Accessed January 2026.
46. National Institute for Health and Care Excellence. NG215: Medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults. 2022. Available at: https://www.nice.org.uk/guidance/ng215. Accessed January 2026.
47. Electronic Medicines Compendium. Gabapentin Rosemont 50mg/ml Oral Solution. 2026. Available at: https://www.medicines.org.uk/emc/product/2868/smpc. Accessed February 2026.
48. General Medical Council. Good practice in proposing, prescribing, providing and managing medicines and devices. 2021. Available at: https://www.gmc-uk.org/professional-standards/the-professional-standards/good-practice-in-prescribing-and-managing-medicines-and-devices. Accessed February 2026.

DRAFT

All Wales gabapentinoid resources for chronic pain
Consultation responses

Respondent and DOI	Page/ section	Comment	Response and action taken
Dr Idris Baker on behalf of National Programme for Palliative & End of Life Care	Is there anything you would like to see **added** to the document?	Some definition of the 'palliative care patients' proposed for exclusion in appendices 5a & 5d and explanation of how they will be identified. To complement this, some explanatory text about why the material does not apply to them and which patients it does not apply to. My assumption is that in people with short life expectancy the resources are not thought to be proportionate or necessary. Depending on which patients are regarded as needing or having palliative care, this judgment might be open to question. The historically very firm delineation between chronic pain and palliative care has begun to break down in a few areas: supportive care for people with cancer uses palliative medicine expertise; closer attention is being paid to the symptom control needs of people with noncancer life shortening illness, characterised by very uncertain survival; and the growing complexity of patients needing palliative care is marked by a growing number of patients each with several serious illnesses. These factors mean that some palliative care patients are in relevant respects very similar to some chronic pain patients. some patients seen by palliative care specialists might have much longer survival and have other risks (notably opioids & benzodiazepines), so I think it is important to consider more closely which patients these materials should be used for and to explain that in the text. I'd welcome an opportunity to engage with you on specific changes we could suggest.	Thank you for your comments. Following this feedback, we met with colleagues from the National Programme for Palliative & End of Life Care to consider the issues raised. As a result, the following amendments have been made: • A definition of palliative care has been included in the glossary. • The scope section has been updated to clarify that the guidance applies to people with chronic pain, including some people receiving palliative care where prognosis is uncertain or extended, while excluding those thought to be in the last months of life where the primary focus is comfort. • A new subsection (1.1.1) has been added within the background chapter addressing people receiving palliative care, outlining relevant risk considerations and the need for proportionate, individualised decision-making. • The titration and review sections have been amended to acknowledge the role of palliative care services and the importance of reviewing functional benefit and harms. • The audit templates have been updated to remove the exclusion of palliative care patients.
Respondent 2: GP Partner Monmouth		Much needed guidance, thank you. I feel you might need to do a separate patient leaflet and contract for patients who are very unhappy/refusing to come off these medications. We have been trying to	Thank you for your feedback. The resources emphasise from the outset that when a gabapentinoid is initiated, a treatment plan should be agreed. This includes setting expectations that treatment will be

		wean people off for years in general practice and find this very explosive! These are often patients with Fibromyalgia/Chronic Backpains/Mental Health/Substance Misuse. An official document to say “it is not prescribed for such conditions due to the serious risks and lack of effectiveness” and a more direct message such as “your healthcare provider will be slowly reducing your medications” A contract might be needed and plenty of information and reassurance to support patients in regards to the withdrawal symptoms.	regularly reviewed and stopped if it does not provide meaningful benefit or if safety concerns arise. A treatment agreement is recommended at initiation so that there is a shared understanding about how the medicine will be used and under what circumstances it may be reduced or stopped (Appendix 2f: Treatment agreement plan – Gabapentin or pregabalin). We recognise, however, that many patients were started on these medicines before this approach was encouraged in practice. We have therefore developed an additional patient information leaflet, Appendix 4b: Patient information leaflet – Reducing your gabapentin or pregabalin for safety reasons, for situations where dose reduction is required for safety reasons despite patient reluctance. This leaflet provides an explanation of the rationale for deprescribing, outlines the expected benefits of reduction, explains how withdrawal symptoms will be managed, and sets out the support that will be offered. We have also developed a treatment agreement template to support discussions with patients about dose reduction (Appendix 4c: Record of agreement – Planned gabapentin or pregabalin reduction).
Carolyn Poulter Primary care pharmacist Cwm Taf Morgannwg	Is there anything you would like to see **added** to the document?	I have reviewed more than 100 patients on gabapentinoids in primary care and I believe the incidence of respiratory depression with gabapentinoids to be underestimated, especially when used with opioids or other sedating medication. I have submitted 7 Yellow cards to report patients who describe “forgetting to breathe,” “breath holding,” “needing to will themselves to breathe” and partner concern. There is also a high incidence of undiagnosed sleep apnoea in patients taking gabapentinoids. Most of these patients are overweight but it is not clear whether a central depressant effect is exacerbating the physical issue. None of the patients described above were what I would consider to be “high-risk” in terms of substance misuse or drug-seeking behaviour. The respiratory concerns were only reported by the patient after I specifically asked them whether they ever “forgot to breathe” or had to “force, or will themselves to breathe” and as such, I feel that clinicians should be more specific when enquiring about “breathing problems.” Many patients will associate “breathing problems” with cough or wheeze, and I therefore feel the information on lines 721, 859, 906 should be more targeted towards	Thank you for your feedback and for sharing your clinical experience. We agree that reduced respiratory drive is an important safety consideration, particularly when gabapentinoids are prescribed alongside opioids or other sedating medicines. We have amended the relevant sections to refer specifically to reduced respiratory drive to support clearer identification of this risk in clinical practice. The tables referenced have also been updated to include reduced respiratory drive as a recognised adverse effect.

		the lack of respiratory drive. This adverse effect needs to be included in table on line 1180, part 5; 1183 part 1 and 1205 4.2	
	Line 618	I wondered whether there was a line missing between week 3 and 4, i.e. a dose of 100mg tds?	This has been amended.
	Letters 1393, 1421 and 1486	I wondered whether you had received any input from Public Health's Behavioural Science Unit on the wording and layout of these draft letters? I have found their comments on correspondence that I send to patients to be helpful.	Thank you for this helpful suggestion. The draft letter templates have been adapted from materials developed and used within health boards and have already been used in practice. We have contacted Public Health's Behavioural Science Unit to seek further feedback on the wording and layout prior to final publication.
Respondent 4: Primary Care Pharmacist with an interest in Analgesic Stewardship. Swansea Bay University Health Board	Is there anything you would like to see added to the document?	Could you consider adding an example template letter for use by GP Practices inviting patients co-prescribed gabapentinoids with an opioid, benzodiazepine or Z drugs for a review to discuss safety concerns? This would be particularly useful as it is one of the key indications for reducing / stopping treatment with gabapentinoids.	Thank you for this suggestion. We have drafted a template letter to support GP practices in inviting patients for a review where gabapentin or pregabalin is co-prescribed with an opioid, benzodiazepine or Z-drug. This is included as Appendix 5f: Example letter – Invitation to review (co-prescribed gabapentin or pregabalin with an opioid, benzodiazepine or Z-drug).
	Is there anything you would like to see **removed** from the document?	Overall, the resource feels overwhelming and difficult to navigate. We appreciate the amount of information there is to share on this topic, but the way in which the pack has been split up into stand alone resources has meant that there is quite a lot of repetition. The coloured summary boxes are great and communicate a lot of the key points. Is all of the additional text necessary?	Thank you for your feedback. The resource has undergone numerous iterations and reviews to meet the needs of different audiences. In developing it, we have aimed to provide both concise summary material and additional explanatory text. These are intended to offer flexibility; users may choose to rely on the summary guides alone or refer to the full resource pack content where additional context is helpful. While this approach may result in some overlap, it would not be appropriate to remove the explanatory text entirely and rely solely on summary information. For a national prescribing resource in a high-risk area, it is important to set out the clinical reasoning and safety considerations underpinning the recommendations. Gabapentinoid prescribing continues to increase despite the introduction of a National Prescribing Indicator in 2017 and reclassification as Schedule 3 controlled drugs (2019). There are also significant safety concerns, including limited evidence outside neuropathic pain, rising deaths involving pregabalin in Wales, and increased enquiries to the Welsh National Poisons Unit. Given this context, the core principles and safety messaging is reinforced at each stage (initiation, review and deprescribing). This emphasis to support safe prescribing in line with MHRA warnings and

			national concerns. For those who prefer a more concise format, the summary guides can be used independently. A Prescriber Quick Reference Guide has also been developed as an alternative to reading the full resource packs. When finalised and published, the summary guides and appendices will be available as standalone documents. In addition, supporting materials have been collated within Resource Pack 5 to streamline access to practical tools. We are also considering how best to present this information digitally on the website to improve navigation and usability.
		The resource is very comprehensive and we acknowledge that there is lots of really useful information included. The coloured boxes and prescriber quick reference guide are particularly helpful and easy to digest. The patient and GP practice resources will also be really useful for us to share with GPs locally. Division of the guidance into four separate packs will help users navigate the resource in practice, however the way in which it has been split up has meant that there is quite a lot of repetition.	Thank you for your comments. The division into separate resource packs is intentional, allowing each pack to function as a standalone document depending on the user's needs. Each resource pack includes a summary guide that can be used independently of the full resource pack. Providing both summary material and additional explanatory text inevitably results in some repetition, as key messages need to be reflected in both formats. Each resource pack is approximately five pages in length excluding appendices (with the exception of the Background pack, which is approximately ten pages without appendices). These appendices and supporting tools have been incorporated within each relevant resource pack, based on user feedback. When published, each resource pack, its summary guide, and the associated appendices will also be available as separate documents. This allows users to access the summary guides alone or refer to the full resource packs where further context is needed.
	Appendix 2c	This patient information leaflet is very long. We're not sure patients would want to read 5 pages or if clinicians would actually utilise it in practice. Could it be made into a more patient friendly leaflet, what are the key points to communicate? Or would it be an option to consider using the new MHRA patient information leaflet which seems shorter and more concise?	The MHRA leaflet and Appendix 2c serve different purposes. The MHRA resource focuses primarily on the safety risks associated with gabapentinoids, including dependence, withdrawal and respiratory depression. Appendix 2c is designed to support shared decision-making when considering whether to start a gabapentinoid for chronic pain. It explains what the medicine is, how it works, the evidence of benefit and its limitations, potential risks (including when used with opioids), and outlines non-pharmacological

			approaches to pain management. It is intended to help patients make an informed decision about treatment options and understand what to expect from a trial of therapy. While the MHRA leaflet is shorter and focused specifically on safety warnings, it does not cover the broader information needed to support a balanced discussion about effectiveness, expectations and alternatives. For this reason, it would not replace Appendix 2c. We have included a link to the MHRA resource within Resource Pack 1 for clinicians who wish to use it specifically when discussing the risks of dependence and withdrawal. In relation to the length of the leaflet, it has been formatted in font size 14 to meet accessibility requirements. This increases the overall page count compared with materials that use smaller font sizes and narrower margins.
	Appendix 2d & 3c	An electronic EMIS templates would be much more useful in practice. We feel that GPs are unlikely to routinely use a template that either need to be printed or individually uploaded to practice systems.	As highlighted in the resource, we have contacted Digital Health and Care Wales (DHCW) to develop an electronic version of the template. This is currently being developed to enable access via EMIS.
	Appendix 5b	We think this is the first reference to EPP and it links to a Gwent website. Should EPP be mentioned earlier on in the document for example in non-pharmacological approaches on page 21? Is the Gwent Association the best reference or is there a national EPP chronic pain programme that is more suitable?	We have amended Appendices 5b and 5c to link to Education Programmes for Patients Cymru (EPP Cymru), which provides a range of self-management courses for people living with long-term health conditions and for carers. The link enables patients to identify courses available in their own area. A link has also been added within the non-pharmacological approaches section of Resource Pack 1.
	Resource pack 4 Page 63 Page 64 Table 11	We've also noticed in the reduction section that the guidance advises to reduce by '10% every 1-2 weeks' in several places. Is this new advice? Is there evidence behind this? We've seen it recommended for opioid reductions previously but not aware of this for gabapentinoids? Is it in line with previous AWMSG resources that advise on gabapentinoid reductions? It is also slightly conflicting with the reduction schedules suggested in Table 11….as reducing gabapentin by 300mg for doses > 900mg will not be 10% for the majority of patients unless they are on the higher doses nearing the max (3600mg). Again, reductions of 50-100mg of Pregabalin aren't going to be 10% for majority of patients unless they are nearing max doses. Think this might be slightly confusing for prescribers and 10%	The wording has been amended to state "approximately 10%." The percentage-based approach was proposed by specialist pain pharmacists within the All Wales Gabapentinoid Task Force and is currently being undertaken in practice in some health boards. We acknowledge that the fixed milligram reductions shown in Table 11 (e.g. 300 mg gabapentin or 50–100 mg pregabalin) will not equate exactly to 10%. The percentage-based approach is presented as an alternative method rather than a requirement, and the document has been updated to include both regimens and to make clear that available formulations should be taken into account when determining dose reductions.

		doesn't seem to be very practical in terms of reasonable doses available. Agree with the approach being gradual, flexible & individualised depending on a number of patient factors.	There is published discussion supporting the use of percentage-based tapering approaches in practice, including the bpacNZ deprescribing guidance (2024) and discussion in the MDU Journal (Summer 2023), which note that reductions of around 5–10% may be used and recalculated at each step. The key principle remains gradual, flexible and individualised dose reduction based on patient response and tolerability.
Respondent 5: GP, Hywel Dda University Health Board		I fully support the development of this document. The emphasis on safe prescribing, shared decision-making, functional outcomes and deprescribing is appropriate and timely given the concerns around gabapentinoids.	Thank you for your comments.
		As a GP, I find these resource packs extremely useful and practical. They are clearly laid out and easy to navigate. Having the information split into separate packs for initiating, reviewing and reducing/stopping treatment makes it much easier to go straight to the section I need during a consultation.	Thank you for your comments.
Rob Bevan. Collated responses from Hywel Dda University Health Board		"As much as possible should be built into national template(s) in EMIS to facilitate considered initiation / review / discontinuation by the busy primary care / general practice team - Community Health Pathways should be involved to ensure this is incorporated into local guidance particularly access to specialist services to support those patients requiring substance misuse support	Thank you for your comments.
		"Think it's a great resource and one I'll definitely be using and sharing (deprescribing element!) once its published Please that older adults are included so much."	Thank you for your comments.
		"I think the Gabapentinoid document is excellent". "…letters and signposting to resources is fab".	Thank you for your comments.

AWTTC
All Wales Therapeutics & Toxicology Centre
Canolfan Therapiwteg a Thocsicoleg Cymru Gyfan

Equality and Health Impact Assessment
All Wales gabapentinoid resources for chronic pain

AWTTC will fill in an Equality and Health Impact Assessment in parallel with each development stage of our projects. This will help us to follow the five ways of working for public bodies, and work to achieving the wellbeing goals, outlined in the Well-Being of Future Generations (Wales) Act 2015.

Date: 06/05/26

1.	AWTTC contact details	Tel: 02921 826900 Email: awttc@wales.nhs.uk
2.	State the objectives of the project.	The *All Wales gabapentinoid resources for chronic pain* are designed to support safe, effective, and evidence-based prescribing of gabapentin and pregabalin for chronic pain. The aims include: • Supporting shared decision-making between healthcare professionals and patients. • Providing clear, practical guidance on the initiation, monitoring, tapering, and deprescribing of gabapentinoids. • Promoting a holistic approach to chronic pain management. • Reducing inappropriate prescribing and addressing risks associated with misuse, dependence, and adverse effects.
3.	Evidence and background information considered. For example: • population data • staff and service users' data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge	This document has been developed in response to increasing concerns about the safety, misuse, and rising harms associated with gabapentinoids in Wales. These concerns are reflected in the growing number of deaths where pregabalin was mentioned on death certificates, alongside a substantial rise in gabapentinoid related enquiries reported to the Welsh National Poisons Unit. Gabapentin and pregabalin were introduced as a National Prescribing Indicator in 2017 and later reclassified as Class C, Schedule 3 controlled drugs. Multiple MHRA warnings have highlighted risks such as dependence, misuse, and respiratory depression. Despite this growing evidence base and clear variation in prescribing across Wales, there has previously been no national guidance to support prescribers in the safe and appropriate use of

	• list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory.	gabapentinoids for pain management. To address this gap, these first All Wales gabapentinoid resources for chronic pain were developed through extensive engagement with the All Wales Gabapentinoid Taskforce, a multidisciplinary group representing health boards, primary and secondary care, pain services, pharmacists, and substance misuse teams. Their collective expertise has aimed to ensure that the guidance is practical, clinically relevant, and designed to promote appropriate and safe prescribing across Wales.
4.	Who will this project affect?	This project affects: • Healthcare professionals involved in pain management. • Patients prescribed or being considered for gabapentinoids for chronic pain. • Carers supporting individuals with chronic pain.

5.0 EQIA – How will the project impact on people?
Questions in this section relate to the impact on people based on the 'protected characteristics' of the Equality Act 2010, and other factors.

How will the project impact on, or affect:	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Actions taken (and who by).
5.1 Age For most purposes, the main categories are people aged: • under 18 years; • between 18 and 65 years; • over 65 years.	The project is expected to have a positive impact on older people, as chronic pain is more prevalent in this age group and gabapentinoids are commonly prescribed as part of its management. Older people may also be at increased risk of adverse effects, polypharmacy, and medication-related harm. The resources provide clear guidance on initiation, review, and deprescribing, supporting safer prescribing and more informed clinical decision-making. No negative impacts related to age have been identified.	N/A	N/A

How will the project impact on, or affect:	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Actions taken (and who by).
5.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes.	The project is expected to have a positive impact on people with disabilities, who may experience chronic pain and be prescribed gabapentinoids. The guidance supports safer prescribing and shared decision-making, with accessible patient materials available.	All related documents published on the AWTTC website will meet accessibility requirements. Any patient-facing materials will also be produced as easy read booklets in Welsh and English.	
5.3 People of different genders: Consider men, women, people undergoing gender reassignment. **N.B.** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender.	We do not expect a potential negative, or unequal, impact on people based on their gender, or on people undergoing gender reassignment.	N/A	N/A
5.4 People who are married or who have a civil partner.	We do not expect a potential negative, or unequal, impact on people based on their marital status or being in a civil partnership.	N/A	N/A
5.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding.	We do not expect a potential negative, or unequal, impact on women who are expecting a baby, are breastfeeding, or are on a break from work after having a baby.	Prescribers should take account of the Summary of Product Characteristics (SmPC) when prescribing pregabalin and gabapentin for	The SmPC criteria specify which people are excluded from treatment due to the associated risks of treatment. This will be

How will the project impact on, or affect:	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Actions taken (and who by).
They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	Manufacturers advise that pregabalin and gabapentin should not be used during pregnancy unless the potential benefit to the mother clearly outweighs the possible risk to the foetus.	women who are pregnant, or who are breastfeeding.	identified for consideration of any change to the advice at the next review if there is a change to the current advice for pregnant and breastfeeding women.
5.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies and travellers, migrant workers. The Runnymede Trust	We do not expect a potential negative, or unequal, impact on people of a different race, nationality, colour, culture or ethnic origin. People of different race and ethnicities can have varying responses to medicines.	N/A	N/A
5.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief. Implications of religious beliefs on selection of medicines (BMJ) In practice: guidance on religion, personal values and beliefs (General Pharmaceutical Council)	We do not expect a potential negative, or unequal, impact on people who have a religion or belief, or people with no religion of belief. Some medicines are made from certain animal products and people might not want to take them because of religion or belief.	N/A	N/A

How will the project impact on, or affect:	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Actions taken (and who by).
5.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual). Stonewall	We do not expect a potential negative, or unequal, impact on people based on who they are attracted to.	N/A	N/A
5.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design.	We do not expect a potential negative, or unequal, impact on people who communicate using the Welsh language.	Any patient-facing materials will be produced in Welsh and English, in line with the Welsh language standards, including easy read booklets.	
5.10 People according to their income related group.	We do not expect a potential negative, or unequal, impact on people based on their income-related group. In Wales, all prescription medicines are free-of-charge for patients; positive recommendations through this project will not affect people depending on their income-related group.	N/A	N/A
5.11 People according to where they live.	We do not expect a potential negative, or unequal, impact on people based on where they live.	N/A	N/A
5.12 Consider others who face health inequalities, such as: • Looked after and accommodated children and young people	We do not expect a potential negative, or unequal, impact on people who face health inequalities.	N/A	N/A

How will the project impact on, or affect:	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Actions taken (and who by).
• Carers: paid/unpaid, family members • People who are homeless or those who experience homelessness: people on the street; those staying temporarily with friends/family; those in hostels/B&Bs • People involved in the criminal justice system: offenders in prison or on probation, ex-offenders • People with addictions and substance misuse problems • People who have poor literacy • People living in remote, rural and island locations			
5.13 Consider any other groups and risk factors relevant to this project.	N/A	N/A	N/A

6.0 HIA – How will the project impact on the health and wellbeing of people in Wales and help address inequalities in health?
Questions in this section relate to the impact on the overall health of individual people, and the impact on the population in Wales.

How will the project impact on, or affect:	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Actions taken (and who by)
6.1 People being able to access the service offered.	We do not expect a potential negative, or unequal, impact on people's ability to access the service offered.	N/A	N/A
6.2 People being able to improve or maintain healthy lifestyles.	We do not expect a potential negative, or unequal, impact on people's ability to improve or maintain healthy lifestyles.	N/A	N/A
6.3 People in terms of their income and employment status.	We do not expect a potential negative, or unequal, impact on people in terms of their income and employment status. Improved pain management may support return to work.	N/A	N/A
6.4 People in terms of their use of the physical environment.	We do not expect a potential negative, or unequal, impact on people's use of the physical environment.	N/A	N/A
6.5 People in terms of social and community influences on their health.	We do not expect a potential negative, or unequal, impact on people in terms of social and community influences on their health. Signposting to lifestyle interventions and social prescribing supports wellbeing	N/A	N/A
6.6 People in terms of macro-economic, environmental and sustainability factors.	We do not expect a potential negative, or unequal, impact on people in terms of macroeconomic, environmental and sustainability factors.	N/A	N/A

7.0 Please fill in section 7.1 after completing the EqHIA, and fill in the action plan.

7.1 Please summarize the potential positive and/or negative impacts of the project.	The introduction of the *All Wales gabapentinoid resources for chronic pain* is expected to have a broadly positive impact on clinical practice and patient care. By providing the first national guidance on the use of gabapentin and pregabalin for pain management, the resource aims to reduce variation in prescribing and support appropriate and more informed decision-making. Clear recommendations on initiation, review, and deprescribing are expected to improve prescribing safety and improve patient outcomes, particularly for groups at higher risk of harm. The inclusion of bilingual and accessible patient materials will support health literacy and more effective shared decision-making. No significant negative impacts have been identified, and the resource is designed to promote equity, clarity, and consistency across Wales.

Action plan for mitigation or improvement and implementation

	Action	**Lead(s)**	**Timescale**	**Actions taken** *(state who by)*
7.2 What are the key actions identified as a result of completing the EqHIA?	The EqHIA highlighted the need to ensure that patient information is clear, accessible, and available in both Welsh and English. Send to AWPAG for consideration. Send out for public consultation. Send to AWPAG for consideration post consultation. Send to AWMSG for endorsement.	AWTTC	 Dec 2025 Jan/Feb 2026 March 2026 May 2026	
7.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment needed?	A more detailed EqHIA is not required.			
7.4 What are the next steps?	Send to AWMSG for consideration and endorsement	AWTTC	May 2026	
7.5 Review of project and EqHIA		AWTTC	[TBC]	

AWTTC's EqHIA template is adapted from the Cardiff & Vale University Health Board EHIA template.