

All Wales gabapentinoid resources for chronic pain

Share your feedback on this resource
by completing our short survey:

[Click Here](#)

SCAN ME



This document has been prepared by the All Wales Gabapentinoid Taskforce, with support from the All Wales Prescribing Advisory Group (AWPAG) and the All Wales Therapeutics and Toxicology Centre (AWTTC), and has subsequently been endorsed by the All Wales Medicines Strategy Group (AWMSG).

Please direct any queries to AWTTC:

All Wales Therapeutics and Toxicology Centre
The Routledge Academic Centre
University Hospital Llandough
Penlan Road
Llandough
Vale of Glamorgan
CF64 2XX

awttc@wales.nhs.uk
029 218 26900

The information in this document is intended to help healthcare providers make an informed decision. This document should not be used as a substitute for professional medical advice and although care has been taken to ensure the information is accurate and complete at the time of publication, the All Wales Therapeutics and Toxicology Centre (AWTTC) and All Wales Medicines Strategy Group (AWMSG) do not make any guarantees to that effect. The information in this document is subject to review and may be updated or withdrawn at any time. AWTTC and AWMSG accept no liability in association with the use of its content. Information presented in this document can be reproduced using the following citation:

All Wales Medicines Strategy Group. All Wales gabapentinoid resources for chronic pain. May 2026.

Copyright AWTTC 2026. All rights reserved.



Grŵp Strategaeth Meddyginiaethau Cymru Gyfan
All Wales Medicines Strategy Group



Contents

Glossary	4
Development of resource packs	6
Rationale	6
Purpose	6
Scope	7
Prescriber quick reference guide	8
Clinical pathway for prescribers	9
Resource pack 1: Background for prescribing a gabapentinoid in chronic pain	11
Key messages – Resource pack 1: Background for prescribing a gabapentinoid in chronic pain	11
1.0 Background for prescribing a gabapentinoid in chronic pain	12
1.1 Patient population.....	12
1.1.1 People receiving palliative care.....	12
1.2 Place in therapy.....	12
1.2.1 Licensed indications.....	12
1.2.2 Off-label use.....	13
1.3 Risks	14
1.3.1 Adverse effects	14
1.3.2 Populations at increased risk of adverse effects	16
1.3.3 Mortality risk.....	18
1.3.4 Dependence.....	19
1.3.5 Misuse.....	19
1.3.6 Legal status.....	21
1.4 Principles of treatment.....	22
Appendix 1a: Information poster for prescribers – Gabapentin and pregabalin	23
Resource pack 2: Initiating a gabapentinoid.....	24
Key messages – Resource pack 2: Initiating a gabapentinoid	24
Summary guide – Resource pack 2: Initiating a gabapentinoid.....	25
2.0 Initiating a gabapentinoid.....	26
2.1 Identifying neuropathic pain	26
2.2 Exploring alternative treatment options before gabapentinoids.....	26
2.2.1 Non-pharmacological approaches.....	26
2.2.2 Social prescribing in chronic pain management:.....	26
2.2.3 Alternative pharmacological treatments	27
2.3 Shared decision making	27
2.4 Setting functional goals	28

All Wales Medicines Strategy Group

2.5 Safety considerations before prescribing	28
2.5.2 Pre-prescribing safety assessment	28
2.6 Choice of gabapentinoid.....	30
2.7 Gabapentinoid trial, dosing and titration	30
2.7.1 Dose adjustment in renal impairment.....	32
2.8 Treatment management plan and documentation	33
Appendix 2a: GP waiting room poster – Living well with pain.....	35
Appendix 2b: Structured consultation when considering gabapentin or pregabalin..	36
Appendix 2c: Patient information leaflet – Gabapentin or pregabalin for pain	40
Appendix 2d: Medicine initiation template – Gabapentin or pregabalin	44
Appendix 2e: Patient trial plan – Gabapentin or pregabalin.....	47
Appendix 2f: Treatment agreement plan – Gabapentin or pregabalin	48
Resource pack 3: Reviewing gabapentinoid use.....	50
Summary guide – Resource pack 3: Reviewing gabapentinoid use.....	50
3.0 Reviewing gabapentinoid use.....	51
3.1 Rationale for review.....	51
3.2 Identifying people for review.....	51
3.3 Planning reviews	52
3.4 Review during the trial period.....	52
3.4.1 Early treatment and stabilisation	52
3.4.2 Evaluating outcomes of the trial	53
3.4.3 Switching between gabapentin and pregabalin.....	53
3.5 Review of long-term use.....	53
3.6 Criteria for continuing or discontinuing treatment	54
3.7 Documentation at review.....	55
3.8 System measures to support reviews.....	55
Appendix 3a: Patient information leaflet – Reviewing your gabapentin or pregabalin for pain	57
Appendix 3b: Patient medication questionnaire – Gabapentin or pregabalin	59
Appendix 3c: Medication review template – Gabapentin and pregabalin	61
Resource pack 4: Reducing and stopping a gabapentinoid.....	64
Summary guide – Resource pack 4: Reducing and stopping a gabapentinoid	64
4.0 Reducing and stopping a gabapentinoid	65
4.1 Principles of safe reduction	65
4.2 Indication for reduction or discontinuation	65
4.3 Preparing the person for tapering.....	66
4.4 Tapering approach and schedule	66
4.5 Management of withdrawal symptoms	67

All Wales gabapentinoid resources for chronic pain

4.6 Re-emergence of neuropathic pain	67
4.7 Reviews during taper.....	68
4.8 Resistance to reduction.....	68
4.9 Discontinuation in people with dependence or ongoing reluctance	69
4.10 Documentation at discontinuation	69
Appendix 4a: Patient information leaflet – Reducing your gabapentin or pregabalin for pain.....	70
Appendix 4b: Patient information leaflet – Reducing your gabapentin or pregabalin for safety reasons	73
Appendix 4c: Record of agreement – Planned gabapentin or pregabalin reduction .	76
Resource pack 5: Auditing gabapentinoid prescribing and supporting tools ..	77
5.0 Auditing gabapentinoid prescribing and supporting tools.....	77
Appendix 5a: Audit template – General review of gabapentin and pregabalin prescribing	78
Appendix 5b: Example letter – Invitation for general gabapentinoid review.....	81
Appendix 5c: Example text message – Invitation for general gabapentinoid review.	82
Appendix 5d: Audit template – Gabapentin and pregabalin prescribing in adults with renal impairment.....	83
Appendix 5e: Example letter – Invitation to review (high dose/renal function).....	86
Appendix 5f: Example letter – Invitation to review (co-prescribed gabapentin or pregabalin with an opioid, benzodiazepine or Z-drug)	87
Appendix 5g: Social media – Patient messages.....	88
6.0 Frequently asked questions.....	89
7.0 Useful patient resources	92
8.0 References	94

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 people 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](#)

All Wales gabapentinoid resources for chronic pain

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 people, 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 $\geq 1,200$ 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 $\geq 10\%$, 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 (<i>feeling unusually "high"</i>)	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 (<i>nausea, vomiting, constipation, diarrhoea, flatulence, dry mouth</i>)	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 (<i>blurred vision, diplopia</i>)	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
<ul style="list-style-type: none"> • 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
<ul style="list-style-type: none"> • 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
<ul style="list-style-type: none"> • 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
<ul style="list-style-type: none"> • 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
<ul style="list-style-type: none"> • 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
<ul style="list-style-type: none"> • 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?

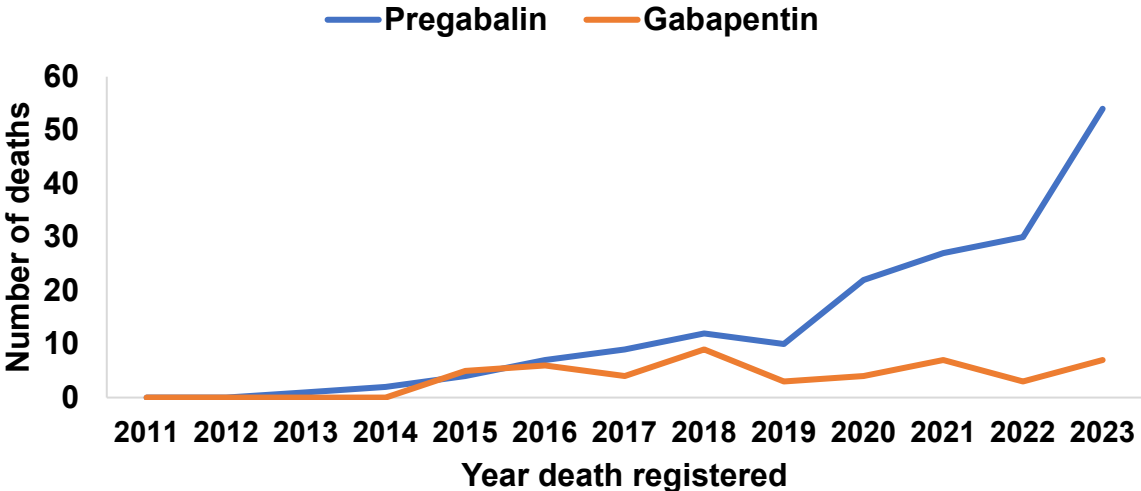
- People at greatest risk of significant adverse effects include:
- **Older people**: increased susceptibility to sedation, confusion, falls and respiratory depression.
 - People with **respiratory disease** (such as COPD): increased risk of severe exacerbations and respiratory depression.
 - People 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 2023²³ (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 certificate⁸



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 sources²⁹, 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

All Wales Medicines Strategy Group

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](#)).
- **Choice of gabapentinoid:** Gabapentin is generally preferred because pregabalin is considered to have greater misuse potential, related to its faster onset of action and recognised euphoric effects. Both medicines carry risks of dependence, withdrawal and respiratory depression (see [section 2.6](#)).
- **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

Gabapentinoids (gabapentin & pregabalin)

Do not prescribe

- Avoid prescribing gabapentinoids with opioids, benzodiazepines, Z-drugs or other CNS depressants
- Gabapentinoids should not be offered as a way of reducing opioid use
- Gabapentinoids should not be routinely offered for off-label conditions: they should not be used for non-neuropathic pain (e.g. chronic primary pain) or where the indication is low back pain (with or without sciatica)

Good practice

- Initial prescribing should ONLY be offered as a trial, with gabapentin preferred because pregabalin has a higher misuse risk
- Doses should be increased weekly as tolerated, aim for lowest effective dose
- A stable therapeutic dose (usually gabapentin $\geq 1,200$ mg/day or pregabalin ≥ 150 mg/day in divided doses) for 4-6 weeks is sufficient to determine benefit
- Benefit is determined as symptom reduction which allows improvements in function

Timely review

Anyone who has received a gabapentinoid for more than 1 year should have a review for efficacy and continued need. Check:

- Is it being taken regularly (daily)? With functional goals being met and the indication still valid? If not then offer reduction and cessation
- No clinically significant adverse effects (sedation, cognitive impairment or falls)
- If co-prescribed with opioids, benzodiazepines, Z-drugs or other CNS depressants, complete a documented risk-benefit review and consider dose reduction or cessation of one or more medicines
- Are doses appropriate for age, co-morbidities and renal function - consider reductions if cessation is not appropriate
- No evidence of dependence, misuse or diversion, with a clear plan for dose reduction or stopping if benefit no longer outweighs harm

Licensed indications

- Gabapentin and pregabalin are licensed for the treatment of peripheral neuropathic pain e.g. painful diabetic neuropathy and post-herpetic neuralgia
- If used in chronic pain, they should only be used where someone presents with clear signs and symptoms of neuropathic pain

Risks

- Gabapentinoids, in particular pregabalin, are associated with addiction, dependence, tolerance and misuse
- People misusing these medicines report improved sociability, euphoria and relaxation
- Systemic gabapentinoid levels can be increased by concurrent opioid use, increasing the risk of respiratory depression, overdose and toxicity
- Caution is needed in renal impairment, frailty and other significant co-morbidities
- Before starting, explain risks, agree functional goals (e.g. improved mobility), and document a review and exit plan

awttc.nhs.wales



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 pain³⁸



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.

2.5.1 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
<u>Renal function (CrCl)</u>	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 <u>section 2.7.1</u>).
<u>Mental health status</u>	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.
<u>Substance use/misuse risk</u>	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).
<u>Cognitive impairment or falls risk</u>	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.
<u>Concomitant opioid use</u>	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.
<u>Other CNS depressants/ alcohol</u>	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.
<u>Respiratory disease</u>	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.
<u>Older people/ frailty</u>	Greater susceptibility to adverse effects (e.g. sedation, cognitive impairment and falls).	Use lower doses and slower titration. Monitor closely.
<u>Driving/ operating machinery</u>	May impair alertness, reaction times and concentration.	Provide advice regarding drowsiness and impaired performance. Follow DVLA guidance; do not drive if affected.
<u>Pregnancy/ contraception</u>	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 considered to have greater misuse potential, related to its faster onset of action and recognised euphoric effects. Both medicines carry risks of dependence, withdrawal and respiratory depression.

Misuse potential of pregabalin



Pregabalin is considered to have **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 $\geq 1,200$ 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 ($\geq 1,200$ 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



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 back pain 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 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, 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 you can manage daily tasks more easily
- doing hobbies or interests more often

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 taking 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 side effects 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. These 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, to take it more often or to 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. These combinations may lead to:

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

Your healthcare worker will consider these risks and may review your medicines.

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 sleepy than usual.

What else can help with my pain?

Medicines are only one part of managing long-lasting (chronic) 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:	<input type="checkbox"/> Neuropathic pain <input type="checkbox"/> Other: _____
Assessment:	LANS score: _____ / 24 (≥ 12 = likely neuropathic pain) <input type="checkbox"/> Clinical assessment
Pain description:	<input type="checkbox"/> Burning <input type="checkbox"/> Shooting <input type="checkbox"/> Tingling <input type="checkbox"/> Numbness <input type="checkbox"/> Electric shock <input type="checkbox"/> Other: _____
Duration:	
Functional impact (baseline – tick all that apply):	<input type="checkbox"/> Sleep disturbance affecting daytime function <input type="checkbox"/> Low mood/distress affecting function <input type="checkbox"/> Reduced mobility (e.g. walking distance, difficulty standing) <input type="checkbox"/> Work/education impact (e.g. off work, reduced hours) <input type="checkbox"/> Social participation (e.g. reduced engagement, isolation) <input type="checkbox"/> Other: _____
Agreed functional goals (required)	1) _____ 2) _____ 3) _____
B. Previous management	
Medications tried:	<input type="checkbox"/> Amitriptyline <input type="checkbox"/> Duloxetine <input type="checkbox"/> NSAIDs <input type="checkbox"/> Paracetamol <input type="checkbox"/> Opioids (Type/Dose: _____) <input type="checkbox"/> Other: _____
Response:	_____ (e.g. ineffective, not tolerated)
Non-pharmacological tried:	<input type="checkbox"/> Physical activity/exercise <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Pacing <input type="checkbox"/> Pain education programmes <input type="checkbox"/> Psychological support (e.g. CBT where available) <input type="checkbox"/> Social prescribing (where available) Wellbeing/Self-help resources: <input type="checkbox"/> Live Well with Pain <input type="checkbox"/> Pain Concern information <input type="checkbox"/> <input type="checkbox"/> Pain Toolkit <input type="checkbox"/> EPP Cymru <input type="checkbox"/> Other: _____

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

All Wales gabapentinoid resources for chronic pain

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	<input type="checkbox"/> No concerns <input type="checkbox"/> Depression <input type="checkbox"/> Suicidal ideation <input type="checkbox"/> Other	Screen for mood disorders and suicidal thoughts. If active risk, avoid or liaise with mental health team.
Substance use/ misuse risk	<input type="checkbox"/> No <input type="checkbox"/> 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	<input type="checkbox"/> No <input type="checkbox"/> Yes	Increased risk of sedation, confusion and falls. Review polypharmacy (particularly CNS depressants and anticholinergics). Start at low dose, titrate slowly.
Respiratory disease	<input type="checkbox"/> No <input type="checkbox"/> 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	<input type="checkbox"/> No <input type="checkbox"/> 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	<input type="checkbox"/> No <input type="checkbox"/> Yes	Includes benzodiazepines, Z-drugs. Additive sedation and respiratory depression risk. Reduce where possible; advise avoiding alcohol.
Older people/ frailty	<input type="checkbox"/> No <input type="checkbox"/> Yes	Higher risk of adverse effects (sedation, cognitive impairment, falls). Use lower doses and slower titration.
Driving	<input type="checkbox"/> No <input type="checkbox"/> Yes	Warn that gabapentinoids can impair reaction times. People should not drive if drowsy. Follow DVLA guidance.
Pregnancy/ contraception	<input type="checkbox"/> No <input type="checkbox"/> 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
<input type="checkbox"/> Gabapentin		Weekly titration preferred in divided doses (e.g. TDS)	Typically, $\geq 1,200$ mg/day (in divided doses)	First-line gabapentin
<input type="checkbox"/> Pregabalin		Weekly titration preferred in divided doses (BD/TDS)	Typically, ≥ 150 mg/day (in divided doses)	Use if gabapentin unsuitable
<p>Prescribing Notes:</p> <ul style="list-style-type: none"> • 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)				
<input type="checkbox"/> Purpose and expectations explained <input type="checkbox"/> Trial period agreed (up to 3 months, including 4–6 weeks at a stable dose) <input type="checkbox"/> Weekly titration schedule discussed <input type="checkbox"/> Adverse effects explained <input type="checkbox"/> Warned not to stop abruptly (withdrawal risk) <input type="checkbox"/> Driving /work safety discussed <input type="checkbox"/> Controlled drug responsibilities explained <input type="checkbox"/> Importance of non-pharmacological management reinforced <input type="checkbox"/> Review and stopping plan agreed				
F. Follow-up plan				
Review	Due in _____ weeks			
At review assess:	<u>Primary outcome:</u> <input type="checkbox"/> Functional improvement (based on agreed goals) <u>Secondary outcomes:</u> <input type="checkbox"/> Pain relief <u>Safety:</u> <input type="checkbox"/> Adverse effects <input type="checkbox"/> Signs of misuse, dependence or diversion			
Decision (based on benefit vs harm):	<input type="checkbox"/> Continue (ONLY if functional improvement demonstrated) <input type="checkbox"/> Maintain lowest effective dose <input type="checkbox"/> Taper and stop (if no meaningful benefit after trial) <input type="checkbox"/> 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 mean 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 taking it;
- 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 (such as morphine, codeine), benzodiazepines (such as diazepam), Z-drugs (such as zopiclone), or other medicines that act on the central nervous system.

Agreed functional goals (what success looks like, agree 2 or 3 specific goals)

1. _____
2. _____
3. _____

Non-pharmacological management

Medication is only **one part** of pain management. We have discussed and agreed:

- Physical activity or physiotherapy
- Pacing or activity management
- Psychological support
- Sleep support
- Supported self-management
- Education and advice
- Other: _____

Review and stopping plan

- Planned medicine 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.



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.

All Wales Medicines Strategy Group

- 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 your medicine is not reviewed, your healthcare worker may not have enough information to decide whether it is safe and appropriate to continue prescribing the medicine.

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

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 sleepy).
- 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 the medicine. 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-lasting (chronic) 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 medicine 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

Complete this before your medication review appointment. Your answers will help your healthcare worker 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?	<input type="checkbox"/> Gabapentin <input type="checkbox"/> Pregabalin <input type="checkbox"/> Not sure										
How long have you been taking it?											
Why was it prescribed?	<input type="checkbox"/> Nerve pain <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Back pain <input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Daily activities (e.g. moving, self-care, work)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Side effects											
Have you noticed any of these? (tick all that apply)	<input type="checkbox"/> Breathing difficulties <input type="checkbox"/> Feeling sleepy <input type="checkbox"/> Dizziness <input type="checkbox"/> Tiredness/low energy <input type="checkbox"/> Problems with memory or concentration <input type="checkbox"/> Poor balance or falls <input type="checkbox"/> Weight gain or increased appetite <input type="checkbox"/> Changes in mood (e.g. low mood, irritability) <input type="checkbox"/> Swollen ankles, feet or hands <input type="checkbox"/> Changes in bowel habits (e.g. constipation or diarrhoea) <input type="checkbox"/> Dry mouth <input type="checkbox"/> Headaches <input type="checkbox"/> Blurred vision <input type="checkbox"/> Other: _____										
Have side effects affected your daily life or wellbeing?	<input type="checkbox"/> Yes (explain: _____) <input type="checkbox"/> 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 symptoms)
- 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 talk about any of these?

- Exercise (at your own pace)
- Physiotherapy
- Doing activities in small amounts
- Pain education programmes
- Sleep and lifestyle support

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 (%)	<input type="checkbox"/> 0 <input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 30 <input type="checkbox"/> 40 <input type="checkbox"/> 50 <input type="checkbox"/> 60 <input type="checkbox"/> 70 <input type="checkbox"/> 80 <input type="checkbox"/> 90 <input type="checkbox"/> 100			
Helps during flare-ups	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partially			
Mood or wellbeing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partially			
Supports daily activity (e.g. moving, washing, dressing)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partially			
Social activities (e.g. seeing people, going out)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partially			
Work or usual daily roles	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partially			
Helps you sleep better (so you function better in the day)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partially			
Still meeting original functional goals	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partially			

[†]An electronic template is currently being developed to allow access to this form via GP system 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Balance problems or falls	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cognitive effects (e.g. memory problems, feeling slowed down)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Weight gain or increased appetite	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Mood changes (e.g. low mood, irritability, anxiety)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Blurred vision or visual disturbance	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Changes in bowel habit (e.g. constipation or diarrhoea)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Swelling of feet, ankles or hands	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Breathing difficulties (e.g. breath-holding or episodes where people feel they must initiate breathing)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other (patient reports):		
6. Dependence/withdrawal features		
Prompt: "Any symptoms if you miss a dose or try cutting down?"		
<input type="checkbox"/> Anxiety/restlessness <input type="checkbox"/> Tremor <input type="checkbox"/> Sweating <input type="checkbox"/> Muscle aches/'flu-like' <input type="checkbox"/> Rebound pain <input type="checkbox"/> Nausea <input type="checkbox"/> 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 (-)	
<input type="checkbox"/> More benefits <input type="checkbox"/> More problems <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Psychological support e.g. CBT if available	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physiotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sleep/stress management	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mindfulness/pacing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Self-management resources e.g. Living Well with Pain, Pain Concern information, Pain Toolkit or EPP Cymru	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

9. Clinical safety and deprescribing		
Risk area	Present?	Action prompt if present
Renal impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Check CrCl → adjust dose; accordingly, consider dose reduction if adverse effects
Concomitant opioid use	<input type="checkbox"/> Yes <input type="checkbox"/> 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)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Review need and reduce total sedative load where possible
Respiratory disease (e.g. COPD, sleep apnoea)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Increased risk of respiratory depression → use caution; consider dose reduction
High dose without clear benefit	<input type="checkbox"/> Yes <input type="checkbox"/> No	Reassess effectiveness → consider reducing dose
Frailty or falls risk	<input type="checkbox"/> Yes <input type="checkbox"/> No	Increased risk of falls and harm → consider lower dose or alternative; review need
Cognitive impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Risk of confusion and harm → review need
Substance use/misuse risk	<input type="checkbox"/> Yes <input type="checkbox"/> No	Consider safer alternatives/ mental health support
If ANY of the above are checked “Yes”, consider <input type="checkbox"/> Gradual dose reduction <input type="checkbox"/> Reduce dose to lowest effective level <input type="checkbox"/> Switch to alternative treatment <input type="checkbox"/> Increase monitoring (e.g. review sooner) <input type="checkbox"/> Refer to: <input type="checkbox"/> Mental health <input type="checkbox"/> Pain team <input type="checkbox"/> Falls team <input type="checkbox"/> 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)	<input type="checkbox"/>	Maintain lowest effective dose
Adjust dose (increase or reduce as appropriate)	<input type="checkbox"/>	↑ only if some benefit; ↓ if adverse effects
Gradual dose reduction (if no meaningful benefit or harms outweigh benefits)	<input type="checkbox"/>	Use stepwise taper
Switch to alternative medicine	<input type="checkbox"/>	Consider if not tolerated
Focus on non-pharmacological support	<input type="checkbox"/>	Reinforce activity, pacing, support
Other plan:	<input type="checkbox"/>	
11. Follow-up and support		
Next review date:		
Resources shared today:	<input type="checkbox"/> Live Well with Pain <input type="checkbox"/> Pain Concern information <input type="checkbox"/> Pain Toolkit <input type="checkbox"/> EPP Cymru <input type="checkbox"/> 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 Council⁴⁵ 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.

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 they will support you. The leaflet 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) or lower back pain with or without 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 sleepy, 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 they recommended reducing this medicine.

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 they can arrange another appointment.

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
- shaking
- flu-like feelings.

These symptoms can be unpleasant but are common and usually improve when the dose is reduced slowly. Symptoms 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 one): 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 I have been given information about reducing this medicine.
2. I understand that I may experience withdrawal symptoms, and I know who to contact if I struggle. My healthcare worker has explained that my dose will be reduced gradually, with review and support, and that the pace of reduction 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.
5. 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.
6. I am responsible for keeping my medicine safe at home. I understand that sharing my medicine is illegal and dangerous.
7. 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](#).
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 AWTTTC.

All Wales gabapentinoid resources for chronic pain

Section 1: Patient data collection table

Excel data collection templates are [available](#).

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		

All Wales Medicines Strategy Group

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 $eGFR < 80 \text{ ml/min/1.73m}^2$
- Adults (≥ 18 years) prescribed pregabalin with $eGFR < 60 \text{ ml/min/1.73m}^2$

Exclusion

- Under 18 years
- People with epilepsy

Method

- Run a search to identify people who are currently receiving prescriptions for gabapentin with an $eGFR < 80 \text{ ml/min/1.73m}^2$.
- Run a search to identify people who are currently receiving prescriptions for pregabalin with an $eGFR < 60 \text{ ml/min/1.73m}^2$.
- 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](#).
- 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 AWTTTC.

Dose adjustment

For renal dose adjustments see [section 2.7.1](#).

All Wales Medicines Strategy Group

Section 1: Patient data collection table

Excel data collection templates are [available](#).

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.pain toolkit.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](#).

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/lanepa/article/PIIS2666-7762\(22\)00275-7/fulltext](https://www.thelancet.com/journals/lanepa/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:

All Wales gabapentinoid resources for chronic pain

- <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-\(ps03-25\)](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.

All Wales Medicines Strategy Group

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](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.

All Wales gabapentinoid resources for chronic pain

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.