

## Appendix 2f: Treatment agreement plan – Gabapentin or pregabalin

Patient name: \_\_\_\_\_ Date: \_\_\_\_\_

Medicine:  Gabapentin  Pregabalin

### Why this medicine is being considered?

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

### Possible risks and side effects

I understand that gabapentin or pregabalin can cause:

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

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

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

### Non-pharmacological management

Medication is **one part** of pain management. The following have been discussed and agreed:

- Physical activity/physiotherapy  Pacing/activity management  
 Psychological support  Sleep support  Supported self-management  Education/advice  Other: \_\_\_\_\_

### Review and stopping plan

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

This agreement plan will be kept in your records and referred to during treatment.

Please tick each box to confirm understanding:

- I understand this medicine may not help my pain.  
 I understand the potential risks and side effects.  
 I understand treatment will only continue if there is clear functional benefit.  
 I understand the medicine will be stopped if it does not help or causes harm.  
 I agree to attend reviews and follow the agreed treatment plan.

Patient signature: \_\_\_\_\_

Prescriber name & signature: \_\_\_\_\_