

## 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<sup>36</sup>. 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<sup>37</sup>. Figure 2 summarises approximate numbers needed to treat (NNT) from a 2025 systematic review and meta-analysis<sup>38</sup>. NNT represents the average number of people who need to be treated for one person to achieve meaningful reduction in pain (defined as at least 50% or 30% reduction in baseline pain intensity or moderate pain relief). As shown in the figure, tricyclic antidepressants (TCAs) (e.g. amitriptyline) and SNRIs (e.g. duloxetine) generally have lower NNTs than gabapentinoids, indicating a greater likelihood of benefit. For gabapentinoids, approximately 1 in 9 people achieve meaningful pain relief.

**Figure 2. NNT for commonly used medicines for neuropathic pain<sup>38</sup>**



### 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<sup>39</sup>.

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<sup>40-42</sup>. Treatment should therefore be framed as aiming to improve function rather than eliminate pain. Complete pain relief is rarely achievable, and unrealistic expectations can contribute to inappropriate long-term prescribing.

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

## 2.4 Setting functional goals

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

## 2.5 Safety considerations before prescribing

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

### 2.5.2 Pre-prescribing safety assessment

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

### Cautions in prescribing

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

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

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

**Monitor for dependence, misuse, and diversion throughout treatment.**



Table 3. Pre-initiation safety check for gabapentinoids

Safety check	Why it matters	Actions to take
<a href="#"><u>Renal function (CrCl)</u></a>	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 <a href="#"><u>section 2.7.1</u></a> ).
<a href="#"><u>Mental health status</u></a>	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.
<a href="#"><u>Substance use/misuse risk</u></a>	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).
<a href="#"><u>Cognitive impairment or falls risk</u></a>	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.
<a href="#"><u>Concomitant opioid use</u></a>	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.
<a href="#"><u>Other CNS depressants/ alcohol</u></a>	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.
<a href="#"><u>Respiratory disease</u></a>	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.
<a href="#"><u>Older people/ frailty</u></a>	Greater susceptibility to adverse effects (e.g. sedation, cognitive impairment and falls).	Use lower doses and slower titration. Monitor closely.
<a href="#"><u>Driving/ operating machinery</u></a>	May impair alertness, reaction times and concentration.	Provide advice regarding drowsiness and impaired performance. Follow DVLA guidance; do not drive if affected.
<a href="#"><u>Pregnancy/ contraception</u></a>	Limited safety data; pregabalin associated with increased risk of congenital malformations.	Where applicable, check pregnancy status. If the person is of childbearing potential, confirm contraception is in place and discuss risks if planning pregnancy.

## 2.6 Choice of gabapentinoid

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

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

### Misuse potential of pregabalin



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

## 2.7 Gabapentinoid trial, dosing and titration

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

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

### Gabapentinoid prescribing and titration



- Start at a low dose and titrate gradually. Although the British National Formulary (BNF) includes daily dose increases, weekly titration is preferred in primary care to reduce adverse effects, minimise harm and unnecessary dose escalation (see **Tables 4** and **6** for dose titration examples).
- Allow adequate time for a therapeutic trial:
  - Gabapentin can take up to 8 weeks for dose titration, followed by 4 weeks at a stable dose.
  - Pregabalin can take up to 4–6 weeks for dose titration, followed by 4 weeks at a stable dose.
- Therapeutic effect is usually observed at doses of:
  - Gabapentin  $\geq$  1,200 mg daily (in divided doses).
  - Pregabalin  $\geq$  150 mg daily (in divided doses)<sup>43,44</sup>.
- **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<sup>8</sup>.
- 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 ( $\geq 150$  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

QR code

Visit:  
[www.livewellwithpain.co.uk](http://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<sup>36</sup>. Self-management can also be encouraged through structured pain management programmes and recognised self-education resources (for example [Live Well with Pain](#), [Pain Concern information](#), the [Pain Toolkit](#), and [EPP Cymru](#)).

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

#### Ask the person:

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

### 2. Are gabapentinoids suitable for your type of pain?

Gabapentinoids are not appropriate for all pain conditions; prescribe only when the indication is licensed.

#### Explain to the person:

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

*If the pain is low back pain with or without sciatica:*

*“The pain you’re experiencing is due to irritation or pressure on a nerve in your lower back. Although it involves a nerve, gabapentinoids have not been shown to be effective for this type of pain and can cause harm through side effects. The most effective approach is self-management, staying active and doing simple back exercises. Leaflets such as [Sciatica and Referred Pain](#) and [Exercises for a Better Back](#) from Backcare provide practical advice.”*

*Alternative (when not neuropathic):*

*“Your pain is not being caused by a problem with the nerves. This means gabapentinoids are unlikely to help. Other treatments, such as exercise or physiotherapy, are usually more effective for this type of pain.”*

### 3. How well do gabapentinoids work for neuropathic pain?

Neuropathic pain is often chronic and difficult to treat. Only a small proportion of people, around one in nine people taking gabapentin or pregabalin for nerve pain, see any meaningful improvement in their pain<sup>38</sup>.

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

#### Ask the person:

*“What are you hoping this medication will do for you?”*

*“Are you comfortable trying a medication that may not work for you?”*

### 4. How will gabapentin or pregabalin be started?

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

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

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

#### Ask the person:

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

### 5. How will we know if the medication is working?

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

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

#### Ask the person:

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

## 6. What if the medication doesn't work?

It's essential that the person understands that:

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

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

### Ask the person:

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

## 7. What are the adverse effects and risks?

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

Key points to discuss include:

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

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

### Ask the person:

*“Are you concerned about potential adverse effects or long-term risks?”*

### 8. What should be known about using gabapentinoids safely?

Gabapentinoids are classed as controlled drugs due to their potential for misuse and dependence. It's important to agree from the outset that:

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

Key points to highlight:

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

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

#### Ask the person:

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

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

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

### Why have I been given this leaflet?

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

### What are gabapentin and pregabalin used for?

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

### How well do gabapentin and pregabalin work?

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

### How could gabapentin or pregabalin help?

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

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

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

### What happens if I decide to try gabapentin or pregabalin?

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

## What side effects might I get?

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

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

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

Talk to your healthcare worker if the side effects:

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

## What happens after the trial?

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

## What if the medicine doesn't work?

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

## Can I become dependent on these medicines?

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

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

## Can these medicines cause addiction?

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

Signs of addiction include:

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

## What if I am also taking other pain medicines?

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

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

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

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

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

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

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

## Can I drive while taking gabapentin or pregabalin?

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

**Can I drink alcohol while taking gabapentin or pregabalin?**

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

**What else can help with my pain?**

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

Visit the AWTTTC 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:	LANSS score: _____ / 24 ( $\geq 12$ = 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"/> <a href="#">Live Well with Pain</a> <input type="checkbox"/> <a href="#">Pain Concern information</a> <input type="checkbox"/> <input type="checkbox"/> <a href="#">Pain Toolkit</a> <input type="checkbox"/> <a href="#">EPP Cymru</a> <input type="checkbox"/> Other: _____

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

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<b>C. Safety checks (pre-initiation)</b>		
<b>Safety check</b>	<b>Findings</b>	<b>Action/Notes</b>
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.

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<b>D. Medication initiated</b>				
<b>Drug</b>	<b>Starting dose</b>	<b>Titration plan</b>	<b>Therapeutic dose range</b>	<b>Reason for choice</b>
<input type="checkbox"/> Gabapentin		Weekly titration preferred in divided doses (e.g. TDS)	Typically, ≥ 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><b>Prescribing Notes:</b></p> <ul style="list-style-type: none"> <li>• Initiate at a low dose and titrate weekly to minimise adverse effects</li> <li>• Adjust for renal function (CrCl)</li> <li>• Consider lower doses and slower titration in older people, frailty, renal impairment, polypharmacy, or known susceptibility to adverse effects</li> <li>• Consider higher doses (e.g. gabapentin ≥ 600 mg TDS or pregabalin ≥ 150 mg BD) only after review and where some benefit demonstrated</li> <li>• Maximum doses are not treatment targets – aim for the lowest effective dose</li> <li>• Do NOT add to repeat until benefit confirmed</li> </ul>				
<b>E. Counselling and advice (tick all completed)</b>				
<input type="checkbox"/> Purpose and expectations explained <input type="checkbox"/> <u>Trial</u> period agreed (up to 3 months, including 4–6 weeks at a stable dose) <input type="checkbox"/> Weekly <u>titration</u> schedule discussed <input type="checkbox"/> <u>Adverse effects</u> explained <input type="checkbox"/> Warned not to stop abruptly ( <u>withdrawal</u> risk) <input type="checkbox"/> <u>Driving</u> /work safety discussed <input type="checkbox"/> <u>Controlled drug</u> responsibilities explained <input type="checkbox"/> Importance of <u>non-pharmacological management</u> reinforced <input type="checkbox"/> <u>Review</u> and <u>stopping</u> plan agreed				
<b>F. Follow-up plan</b>				
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 indicate that the medicine will continue to be helpful in the long term.**

Please return all unused medicines to your local pharmacy.

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

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

Medicine:  Gabapentin  Pregabalin

### Why this medicine is being considered?

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

### Possible risks and side effects

I understand that gabapentin or pregabalin can cause:

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

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

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

### Non-pharmacological management

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

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

### Review and stopping plan

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

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

Please tick each box to confirm understanding:

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

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

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