Resource pack 2: Initiating a gabapentinoid

Key messages – Resource pack 2: Initiating a gabapentinoid

DO

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

DON'T

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

Summary guide – Resource pack 2: Initiating a gabapentinoid

1. Initiation assessment

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

2. Shared decision-making and consent

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

3. Choice of medicine

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

4. Therapeutic trial and dosing

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

5. Renal impairment

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

6. Monitoring and safety

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

7. Prescribing and supply rules

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

8. Documentation

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

2.0 Initiating a gabapentinoid

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

2.1 Identifying neuropathic pain

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

2.2 Exploring alternative treatment options before gabapentinoids

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

2.2.1 Non-pharmacological approaches

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

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

2.2.2 Social prescribing in chronic pain management:

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

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

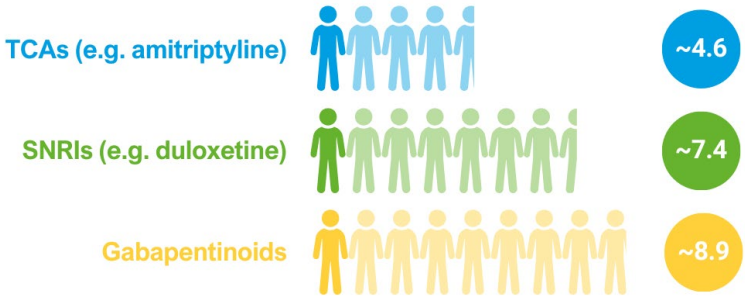
- Support self-management and functional improvement, and reduce reliance on long-term analgesics.
- Complement physiotherapy and pain-management programmes by addressing social, emotional and lifestyle factors.
- Support people who may be struggling with low mood, fear of movement, poor sleep or limited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

2.2.3 Alternative pharmacological treatments

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

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

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



2.3 Shared decision making

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

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

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

2.4 Setting functional goals

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

2.5 Safety considerations before prescribing

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

2.5.2 Pre-prescribing safety assessment

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

Cautions in prescribing

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

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

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

Monitor for dependence, misuse, and diversion throughout treatment.

Table 3. Pre-initiation safety check for gabapentinoids

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

2.6 Choice of gabapentinoid

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

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

Misuse potential of pregabalin

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

2.7 Gabapentinoid trial, dosing and titration

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

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

Gabapentinoid prescribing and titration

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

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

Table 4. Recommended titration schedule for gabapentin

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

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

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

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

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

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

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

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

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

Adding a gabapentinoid to repeat medications

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

2.7.1 Dose adjustment in renal impairment

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

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

Table 8. Renal dose adjustments for gabapentin

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

Table 9. Renal dose adjustments for pregabalin

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

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

2.8 Treatment management plan and documentation

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

Treatment plan requirements

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

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

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

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