





## **Pregabalin Prescribing Guidelines for Neuropathic Pain**

## **Summary of key prescribing points:**

- Consider the potential for misuse before prescribing pregabalin. There are published reports of both
  pregabalin and gabapentin abuse, particularly in the substance misuse population. Also consider the
  potential for illicit diversion either by choice or through coercion.
- Ensure all prescriptions for pregabalin are reviewed on a regular basis by limiting the authorisation period.
- Ensure prescriptions are not ordered more frequently than necessary, without valid reason.
- Exercise vigilance for all requests for pregabalin by name.
- Always confirm new requests with previous prescriber for new patients / temporary residents etc.
- If a gabapentinoid is necessary, consider changing over to gabapentin.
- Regularly review and assess the patient with a view to dose reduction.
- Ensure the dose is optimised to **TWICE a day** (BD) dosing, rather than THREE times a day (TDS), as this is more cost effective. It also limits the amount of medication available for illicit diversion.
- Limit the amount prescribed to 28 days maximum, or even 7 days where there is concern.
- Discuss any concerns regarding misuse with Phoenix Futures or Barnsley Drugs and Alcohol Action Team (DAAT)
- If patient participates in a needle exchange scheme, be aware the contents of capsules can be opened and injected. There have been verbal reports that pregabalin maybe preferred to heroin.

This extract has been taken from the Pregabalin Prescribing Guidelines which were ratified by the Area Prescribing Committee in May 2014. The full guideline can be accessed at the following link:

http://www.barnsleyccg.nhs.uk/CCG%20Downloads/Members/Medicines%20management/Prescribing%20Guide lines/Pregabalin%20for%20neuropathic%20pain%20prescribing%20guidelines%20-%20July%202014.pdf







## **Drug Management of Neuropathic Pain**

Neuropathic pain not responding to simple analgesia and with symptoms such as sleep disturbances, depression and interference with normal daily activities can be managed using the suggested algorithm below. All patients should have regular clinical reviews, and have early reviews following medication changes. Once satisfactory pain control is achieved with any medication, treatment should then be continued. If improvement is sustained consideration may be given to reducing the dose gradually over time following consultation with the patient.

NICE Clinical Guideline (CG173)<sup>1</sup> for the pharmacological management of neuropathic pain and the NICE pathway for managing the long term complications of type 2 diabetes<sup>2</sup> advises initial treatment with one of the four options listed below. If initial treatment with oral medication is not effective or not tolerated, offer one of the remaining three oral drugs. Consider switching again if the second or third drugs tried are also not effective or not tolerated. (Please consult relevant SPC for further information when prescribing these drugs<sup>3</sup>)

Local guidelines for the prescribing of pregabalin are available at <a href="http://www.barnsleyccg.nhs.uk/members-">http://www.barnsleyccg.nhs.uk/members-</a> professionals/prescribing-guidelines-list.htm . These guidelines have been produced in response to an increase in the prescribing of pregabalin locally, as well as the increase in illicit use.

## All types of Neuropathic pain (other than trigeminal neuralgia) Amitriptyline (where no cautions or contraindications). Off-label. Start 10mg 6-8pm to reduce 'hangover' effect £0.83-1.75 Increase gradually by 10mg/week to an effective or maximum tolerated dose / 28 days STEP 1 Aim for at least 25mg nocte (not above 75mg) Inadequate response after 8 week trial or not tolerated discontinue Gabapentin (capsules are more cost effective) Start: Day1=300mg, Day 2=300mg bd, Day 3=300mg tds Slower dose titration in 100mg increments may help improve tolerability Increase gradually in 300mg/day increments every 2-3 days to an effective or £3.98-8.46 STEP 2 maximum tolerated dose / 28 days Aim for at least 600mg tds (maximum 1.2g tds) Allow 1 week to reach 1.2g/day, 2 weeks for 2.4g/day and 3 weeks for 3.6g/day Inadequate response after 8 week trial or not tolerated discontinue **Duloxetine** £27.72-Start 60mg od (maintenance dose), up to maximum 60mg bd (no evidence at £55.44 / 28 higher dose) days **OR Pregabalin** STEP 3 Start 75mg bd (25mg bd may be required when used in elderly patients Increase if necessary after 3-7 days to 150mg bd, then further 7 days to maximum 300mg bd £64.40 / 28 Prescribe as bd dose (no benefit in tds) and AVOID double dosing e.g. 2bd days

Consider whether combination therapy, pain clinic referral or psychological support is appropriate. Consider referral to pain clinic (or other appropriate service e.g. diabetic clinic) at any time if the patient has severe pain, the pain significantly limits the patient's daily activities and participation, or if the patient's underlying health condition has deteriorated.

If first choice is not tolerated or inadequate response after 8 week trial -

discontinue and try other drug