GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Abertawe Bro Morgannwg
University Health Board

Medication review form

To be completed with the patient during face-to-face review in practice

Patient ID **Age**

Pain related diagnosis

Is there an existing neuropathic element to this condition? Y/N (if Y then detail)

What drugs have been taken for pain in the last month?

Drug	Dose	How often	Have they helped pain? 0% = no help 100% = totally help	Have there been any adverse effects –if yes describe adverse effect
				Y/N
				Y/N
				Y/N
				Y/N

Assessment of current effectiveness

DATE	**Score 0 – 10 (0 = no improvement, 10 = 100% improvement)**
Analgesia score	
Functional improvement (ability to do daily physical activities)	
Sleep improvement	
Change in mood	
Overall quality of life improvement	
Able to return to work or stay in work	Y N

A - Adverse effects of medication (tick all that apply)

Concentration difficulties	**Constipation**	**Sickness**	**Dizziness**
Weight gain	**Hallucinations / bad dreams**	**Depression / low mood**	**Rashes**
Blurred vision	**Dry mouth**	**Sexual difficulties**	**Breathing difficulties**
Others (complete in boxes)			

B - Does the patient ever experience the following? (even without missing a dose) (tick all that apply)

Shaking	**Tremors**	**Nausea**	**Vomiting**
Diarrhoea	**Itching**	**Aching muscles**	**Severe anxiety / paranoia**

Has the pain relief reduced over time – even if the dose has increased? Y / N

C - Do the medicines help the patient: (tick all that apply)

Deal with setbacks and high pain levels	**Feel good about themselves**
Feel more relaxed even if the pain doesn't go away	Get a good night's sleep because pain is relieved
Keep doing the things that are important to them	**Forget about other problems they have (not always pain related)**
Help the patient to remain in work	Undertake regular exercise / stretching / activity

Medicines should only be continued where patient is demonstrating functional improvement and pain reduction.

Where patients report adverse effects or lack of pain reduction and/or lack of functional improvement, it is safer to reduce and where possible, stop the medicines, even if there is no alternative medicine to offer.

Outcomes:

- Report of at least one 'red' symptom in tables A, B and C is an indication to suggest and encourage a reduction of medication in order to improve the patient's safety and general well-being
- Report of lessening effect even with increasing dose is a potential sign of 'treatment failure' and best evidence suggests reducing medication to lowest tolerated dose or stopping rather than continuing or increasing doses further
- Check indication for medication – Gabapentinoids should only be prescribed where there is a evidence of neuropathic changes / pain
- Total dose of strong opioid ≥ 60mg twice daily morphine or equivalent are not recommended for non-cancer pain and efforts should be made to encourage reduction

Tapering Opioids and Gabapentinoids

General advice

- **Reductions should be agreed with the patient wherever possible**
  - Non-engagement however, is not a reason to not reduce medicines where there are safety concerns or where it is believed to be in the person's best interest
- **Only reduce one medicine at a time**
  - Decide with the person which medicine they prefer to reduce first
  - Doses of opioids >120mg morphine equivalence per day should be highlighted as a priority
- **Use small dose changes**
  - This helps to instil confidence in the person as small reductions are less likely to cause withdrawal
  - Dose reductions can always be increased but going too high and too fast can cause harm
- **Reduce the dose the person thinks is going to work best for them**
  - The examples here start in the morning but if the person wants to starts by reducing the evening dose for example, go with that
- **Take time to make changes**
  - Advice to reduce opioids by 10% of total dose per week comes from addiction management and is not suitable for Primary Care reductions where there is limited psychological support etc
  - Changes can be made weekly, fortnightly or monthly – whatever the person thinks they can manage
  - Timing of changes may alter during the process depending on the individual's experience of reducing doses
- **Give exact quantities and stipulate the reduction in the dosing instructions**
  - **Remove the medicine being reduced from repeat prescribing**
  - Only provide enough medication to undertake 2 reductions at a time maximum (for weekly or fortnightly reductions)
  - Clearly explain the reduction on each prescription even where a tapering sheet is provided
- **Review frequently**
  - Where possible, review the person before each reduction
  - This can be a telephone call to check the patient is managing and not suffering any untoward effects of reducing their dose
  - Tapering doses safely is potentially time-consuming but is an extremely worthwhile intervention

Example tapers

- **These are for guidance and are not prescriptive**
- Each taper needs to be individualised to the person making the reductions
- Agree a maximum of two reductions with each review
- Tapering sheets are provided to assist with the changes – complete for the individual's agreed reduction
- The aim should not necessarily be to stop, unless the prescriber and person agree that is in the person's best interests / is what they want to do. Aim initially to get people into the 'safer zone' of prescribing (doses under 120mg morphine equivalent per day)

Opioids

Morphine MR (e.g. starting at 200mg twice daily)

Change	Morning Dose	Evening Dose
1	190mg	190mg
2	180mg	180mg
3	170mg	170mg
4	160mg	160mg
5	150mg	150mg
6	140mg	140mg
7	130mg	130mg
8	120mg	120mg
9	110mg	110mg
10	100mg	100mg
11	95mg	95mg
12	90mg	90mg
13	85mg	85mg
14	80mg	80mg
15	75mg	75mg
16	70mg	70mg
17	65mg	65mg
18	60mg	60mg
19	55mg	55mg
20	50mg	55mg
21	50mg	50mg
22	45mg	50mg
23	45mg	45mg
24	40mg	45mg
25	40mg	40mg
26	35mg	40mg
27	35mg	35mg
28	30mg	35mg
29	30mg	30mg
30	25mg	30mg

31	25mg	25mg
32	20mg	20mg
33	15mg	20mg
34	15mg	15mg
35	10mg	15mg
36	10mg	10mg
37	5mg	10mg
38	5mg	5mg
39	STOP	5mg
40	STOP	STOP

- 5mg morphine MR is currently only available as MST Continus® tablets
- Doses can be 'see-sawed' down if changing both doses is too much for the person at the higher doses. 'See-saw' dose means reducing only one of the doses each time e.g. morning dose reduced, then evening dose – as seen at the lower dose reductions.

Oxycodone SR (e.g. starting at 100mg twice daily)

Change	Morning Dose	Evening Dose
1	95mg	95mg
2	90mg	90mg
3	85mg	85mg
4	80mg	80mg
5	75mg	75mg
6	70mg	70mg
7	65mg	65mg
8	60mg	60mg
9	55mg	55mg
10	50mg	50mg
11	45mg	45mg
12	40mg	40mg
13	35mg	40mg
14	35mg	35mg
15	30mg	35mg
16	30mg	30mg
17	25mg	30mg
18	25mg	25mg
19	20mg	25mg
20	20mg	20mg
21	15mg	20mg
22	15mg	15mg
23	10mg	15mg
24	10mg	10mg
25	5mg	10mg

26	5mg	5mg
27	STOP	5mg
28	STOP	STOP

- Doses can be 'see-sawed' down if changing both doses is too much for the person at the higher doses. 'See-saw' dose means reducing only one of the doses each time e.g. morning dose reduced, then evening dose – as seen at the lower dose reductions.

Tapentadol MR (e.g. starting at 250mg twice daily)

Change	Morning Dose	Evening Dose
1	200mg	250mg
2	200mg	200mg
3	150mg	200mg
4	150mg	150mg
5	100mg	150mg
6	100mg	100mg
7	50mg	100mg
8	50mg	50mg
9	STOP	50mg
10	STOP	STOP

- Tapentadol can be a difficult drug to reduce due to its dual action as an opioid and noradrenaline reuptake inhibitor, which makes its effects less predictable.
- Each 50mg tapentadol is roughly equivalent to 20mg morphine, meaning that removing a morning and evening dose simultaneously is generally far too fast to reduce someone – therefore, doses should be 'see-sawed' down.
- If someone is finding reducing tapentadol too difficult, it may be necessary to convert them to morphine and then step down more slowly

Fentanyl patches (e.g. starting at 200 micrograms/hour changed every three days)

Change	Morning Dose	How to prescribe
1	187 micrograms/hour	1x100mcg/h + 75mcg/h + 12mcg/h
2	175 micrograms/hour	1x100mcg/h + 75mcg/h
3	162 micrograms/hour	1x100mcg/h + 50mcg/h + 12mcg/h
4	150 micrograms/hour	1x100mcg/h + 50mcg/h
5	137 micrograms/hour	1x100mcg/h + 25mcg/h + 12mcg/h
6	125 micrograms/hour	1x100mcg/h + 25mcg/h
7	112 micrograms/hour	1x100mcg/h + 12mcg/h
8	100 micrograms/hour	1x100mcg/h
9	87 micrograms/hour	1x75mcg/h + 1x12mcg/h

10	**75 micrograms/hour**	**1x75mcg/h**
11	**62 micrograms/hour**	**1x50mcg/h + 12mcg/h**
12	**50 micrograms/hour**	**1x50mcg/h**
13	**37 micrograms/hour**	**1x25mcg/h + 12mcg/h**
14	**25 micrograms/hour**	**1x25mcg/h**
15	**12micrograms/hour**	**1x12mcg/h**
16	**STOP**	**STOP**

- Each 12 microgram/hour patch is roughly equivalent to 45mg morphine. This makes each change a significant proportion of the total dose. Patches should be changed every three days but changes in total dose are often better monthly or fortnightly at the most to give people sufficient time to adjust to the changes.
- When doses of fentanyl patches reach around 50 micrograms/hour, it may be easier for the person to change to morphine (roughly 160-180mg/day) and then reduce in smaller amounts according to the morphine reduction plan

Buprenorphine patches (e.g. starting at 140 micrograms/hour changed twice a week)

Change	Morning Dose	How to prescribe
1	**122.5 microgram/hour**	**1x70mcg/h + 1x52.5mcg/h changed twice a week**
2	**105 micrograms/hour**	**1x70mcg/h + 1x35mcg/h changed twice a week**
3	**87.5 micrograms/hour**	**1x52.5mcg/h + 35mcg/h changed twice a week**
4	**70 microgram/hour**	**1x70mcg/h changed twice a week**
5	**52.5 micrograms/hour**	**1x52.5mcg/h changed twice a week**
6	**40 micrograms/hour**	**2x20mcg/h changed weekly**
7	**35 micrograms/hour**	**1x20mcg/h + 1x15mcg/h changed weekly**
8	**30 micrograms/hour**	**1x20mcg/h + 10mcg/h changed weekly**
9	**25micrograms/hour**	**1x20mcg/h + 1x5mcg/hour changed weekly**
10	**20 micrograms/hour**	**1x20mcg/h changed weekly**
11	**15 micrograms/hour**	**1x15mcg/h changed weekly**
12	**10 micrograms/hour**	**1x10mcg/h changed weekly**
13	**5 micrograms/hour**	**1x5mcg/h changed weekly**
14	**STOP**	**STOP**

Gabapentin (e.g. starting at 1200mg three times a day, 300mg per dose reduction)

Change	Morning Dose	Midday Dose	Evening Dose
1	900mg	1200mg	1200mg
2	900mg	900mg	1200mg
3	900mg	900mg	900mg
4	600mg	900mg	900mg
5	600mg	600mg	900mg
6	600mg	600mg	600mg
7	300mg	600mg	600mg
8	300mg	300mg	600mg
9	300mg	300mg	300mg
10	STOP	300mg	300mg
11	STOP	STOP	300mg
12	STOP	STOP	STOP

Gabapentin (e.g. starting at 1200mg three times a day, 100mg per dose reduction)

Change	Morning Dose	Midday Dose	Evening Dose
1	1100mg	1100mg	1100mg
2	1000mg	1000mg	1000mg
3	900mg	900mg	900mg
4	800mg	800mg	800mg
5	700mg	700mg	700mg
6	600mg	600mg	600mg
7	500mg	500mg	500mg
8	400mg	400mg	400mg
9	300mg	300mg	300mg
10	200mg	200mg	200mg
11	100mg	100mg	100mg
12	STOP	STOP	STOP

- If the person is struggling with gabapentin reductions, then consider reducing more slowly e.g. by 100mg of a single dose per week/fortnight.
    - This could look like e.g. 900mg / 1000mg / 1000mg for one week then 900mg / 900mg / 1000mg for one week etc.

Pregabalin (e.g. starting at 300mg twice daily, 50mg dose reductions)

Change	Morning Dose		Evening Dose
1	250mg		300mg
2	250mg		250mg
3	200mg		250mg
4	200mg		200mg
5	150mg		200mg
6	150mg		150mg
7	100mg		150mg
8	100mg		100mg
9	50mg		100mg
10	50mg		50mg
11	STOP		50mg
12	STOP		STOP

Pregabalin (e.g. starting at 300mg twice daily, 25mg reductions)

Change	Morning Dose		Evening Dose
1	275mg		275mg
2	250mg		250mg
3	225mg		225mg
4	200mg		200mg
5	175mg		175mg
6	150mg		150mg
7	125mg		125mg
8	100mg		100mg
9	75mg		75mg
10	50mg		50mg
11	25mg		25mg
12	STOP		STOP

- If the person is struggling with pregabalin reductions, then consider reducing more slowly e.g. by 25mg of a single dose per week/fortnight.
    - This could look like e.g. 275mg / 300mg for one week then 275mg / 275mg for one week etc.