Health and Social Care Board

To: Community Pharmacies

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Dear Colleague

RE: Awareness of pregabalin abuse / misuse in NI

The purpose of this correspondence is to highlight the:

- Increasing risks associated with pregabalin use
- Practical steps to be taken with respect to minimising potential abuse / misuse during dispensing of pregabalin

Most patients use pregabalin responsibly but deaths involving pregabalin and gabapentin are on the rise. Currently, pregabalin appears to be more sought after for misuse and abuse than gabapentin and there is a growing illegal market. Although both have a similar mechanism of action and have potential for misuse, the pharmacokinetic properties of pregabalin make the drug relatively more dangerous than gabapentin in high doses.

Patients may have unrealistic expectations or goals from their medication. A 30% reduction in pain is considered a good outcome, a 50% improvement is considered significant. It is unrealistic to expect 100% improvement in symptoms. Therefore, before the drug is initiated, patients need to be counselled on the need for regular review and the potential side effects of the drugs, including abuse or dependence.

The Code places a requirement on all pharmacists to provide safe, effective and quality care. Standard 2.1.2.requires that pharmacists "**effectively control and manage the sale or supply of medicinal and related products paying particular attention to those with a potential for abuse and dependency**."

Community pharmacists are, therefore, asked to brief their staff on the abuse or misuse potential of pregabalin and to consider ways to reduce preventable risks. For example:

1. **Collection of pregabalin prescriptions from the pharmacy**: if people other than the patient repeatedly collect prescriptions for pregabalin when the pharmacy has not had contact with the patient to authorise this, the pharmacist should make contact with the patient to confirm the arrangement. If contact cannot be made with the patient, the pharmacist should contact the prescriber to make them aware of the situation.

2. **Delivery of pregabalin**: where a delivery service is provided the pharmacist should consider excluding drugs such as pregabalin from the service if an alternative method of supply is available. Where a delivery service for pregabalin is provided a signature should be obtained to indicate safe receipt of the pregabalin.
3. **Overdosing / overuse**: if prescriptions are brought for dispensing too frequently or if the patient is taking more than the maximum daily dose (600mg) then the prescriber should be contacted.
4. **Requests for emergency supplies of pregabalin**: pharmacists are required to take the necessary steps to ensure such requests are appropriate e.g. phoning the patient's prescriber to confirm use.
5. **Handwritten amendments to pregabalin prescriptions**: prescribers have been asked to delete the prescription and issue a new one if a mistake is made on a pregabalin prescription. This should make it easier to identify alterations made by someone other than the prescriber. You may wish to check with local surgeries if they will be adopting this practice.

GPs in primary care are also being asked to be extra vigilant in their initiation, repeat prescribing and review of pregabalin.

Links to additional information and resources are included at the end of this letter.

Thank you for your help in this matter.

Yours sincerely

Mr Joe Brogan
Assistant Director of Integrated Care
Head of Pharmacy & Medicines Management

Enc.

1. Non-Malignant Neuropathic Pain Conditions in Non-Specialist Settings

Other references:

1. NIMM_NewsletterVol7PainSupplementJuly16.pdf: http://niformulary.hscni.net/PrescribingNewsletters/PDF/NIMM_2016/NIMM_NewsletterVol7PainSupplementJuly16.pdf

2. http://niformulary.hscni.net/Formulary/Adult/PDF/PregabalinAndGabapentinRiskOfMisuseAdviceHSCBWebVersion.pdf

Implementation Support Tool for Non-Malignant Neuropathic Pain Conditions in Non-Specialist Settings

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AMITRIPTYLINE* tablets

– start at 10mg and titrate by 10mg a week until 70-75mg daily is reached (as a single dose in the evening). Maximum tolerated dose should be used for 4 weeks before benefits can be judged.

- A 'worthwhile benefit' would be considered to be an improvement in pain or decrease in sleep disturbance.
- Care with drug interactions, comorbidities, and use in the elderly.
- If amitriptyline gives satisfactory pain reduction but is not tolerated due to adverse effects – consider oral nortriptyline* as an alternative at the same dose (as amitriptyline).

** These agents are not licensed for neuropathic pain but the evidence for treatment efficacy and safety is deemed sufficient to make this recommendation.*

GABAPENTIN capsules

– start at 300mg nocte (100mg if patient very frail or very susceptible to sedative medications). Titrate up in steps of 300mg daily (with total given in 3 divided doses) according to side effects/response, up to maximum of 3.6 grams.

- Once on maximum tolerated dose wait for 2 to 4 weeks to assess if there is a worthwhile benefit.
- STOP IF NO BENEFIT (slowly over 4 weeks)
- After 6 months of successful treatment attempt dose reduction or cessation.

DULOXETINE caps

– start at 30mg daily and titrate up to a max of 60mg BD.
A lower starting dose may be appropriate in some people.
Nausea is common on initiation but may resolve on continued treatment.

PREGABALIN capsules

– start at 75mg nocte. This can then be titrated according to side effects to a maximum of 600mg daily in **two** divided doses. A more conservative dose schedule may be considered in the elderly (e.g.25mg BD)

- Once on maximum tolerated dose wait for 2 to 4 weeks to assess if there is a worthwhile benefit.
- STOP IF NO BENEFIT (slowly over 4 weeks)
- After 6 months of successful treatment attempt dose reduction or cessation.

Notes:

Non–Pharmacological Interventions
The psychological aspects of pain must not be overlooked in the management of neuropathic pain. Coping strategies can be found within:

- www.paintoolkit.org

Gabapentin / Pregabalin
Weight gain can occur with both gabapentin and pregabalin and is not a reason to switch between these therapeutic options. If switching between gabapentin and pregabalin there is no washout period necessary.

The full NICE guideline for Neuropathic Pain can be found here.

Carbamazepine
Is recommended as initial treatment for trigeminal neuralgia.

Tramadol MR
100–400mg daily in 2 divided doses (as modified release preparation). NICE recommend tramadol if acute rescue therapy is needed and only for long term use if advised by a specialist.

Capsaicin cream
Is an option for localised pain if oral treatment is to be avoided or not tolerated.

Capsaicin patch
This is a Red List drug and should be used in a specialist setting only.

Opioids
Neuropathic pain is not particularly responsive to opioid analgesics. NICE do not recommend starting treatments with opioids unless advised by a specialist to do so. See HSCB guidance on Opioids in Non-Malignant Pain.

Tapentadol MR
May be recommended as a sole agent for mixed (neuropathic/nociceptive) pain in a specialist setting.

Lidocaine Plasters
NICE does not recommend Lidocaine plasters for treatment of neuropathic pain.

Updated March 2014