Health and Social Care Board

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To: All GP Practices

28th October 2016

Dear Colleague

RE: Awareness of pregabalin abuse / misuse in NI

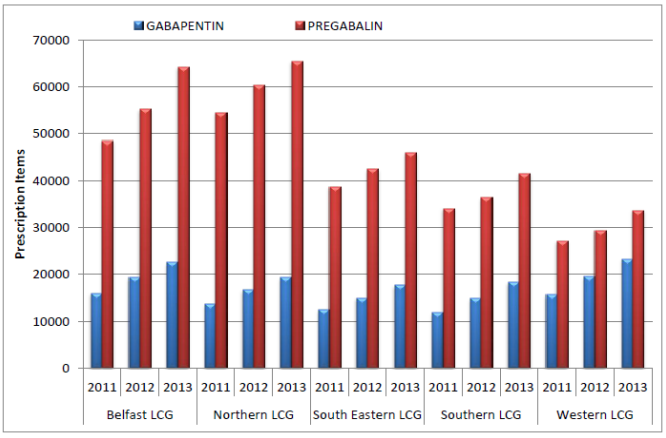
The purpose of this correspondence is to highlight

- Increasing risks associated with pregabalin use
- Increasing volumes in usage
- Practical steps to minimise potential abuse / misuse during prescribing of pregabalin
- Guidance in relation to prescribing pregabalin for neuropathic pain

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.

There is significant variation in use of pregabalin between LCG areas and these differences are unlikely to be accounted for by demographic reasons alone:

Variation in prescribing of gabapentin and pregabalin across LCGs



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.

Practices are asked to brief their staff on the issues regarding potential abuse or misuse of pregabalin and to put in place steps to reduce the risk of such an occurrence. For example:

1. **Review patients prescribed pregabalin regularly**: when patients are started on pregabalin, they should be advised that the medication will be stopped if there is no benefit. If treatment is successful there should be an attempt after 6 months to reduce the dose or stop. Support staff should highlight missed review dates to the prescriber. Any dose reduction / cessation of treatment should be done in line with guidance: http://niformulary.hscni.net/PrescribingNewsletters/PDF/NIMM_2016/NIMM_NewsletterVol7PainSupplementJuly16.pdf

2. **Consider restricting prescribing of pregabalin to 30 days' supply per prescription**.

3. **Be aware of collection of pregabalin prescriptions from the practice**: if people other than the patient repeatedly collect prescriptions for pregabalin when the practice has not had contact with the patient to authorise this, the practice should make contact with the patient to confirm the arrangement. If contact cannot be made with the patient, the practice should write to the patient asking them to attend for review.

4. **Be vigilant for overdosing / overuse**: there have been a number of adverse incidents in Northern Ireland involving pregabalin. If prescriptions are requested too frequently or if the patient is taking more than the maximum daily dose (600mg) then the patient should be urgently reviewed.

5. **Do not make hand amendments to pregabalin prescriptions**: if a mistake is made then the prescription should be deleted and a new prescription issued. This will make it easier for community pharmacists to pick up if prescriptions have been altered by someone other than the prescriber.

6. **Prescription security**: practices should be aware of the need for prescription security for both unused forms and those already generated and signed. For example, patients should not be left alone in a room with access to blank prescription forms (including those left in the printer). There have been thefts of forms in such circumstances which were then used in an attempt to obtain pregabalin.
   Prescriptions that are signed and awaiting collection should be securely out of reach of people other than staff and locked away in the evening. Signed prescriptions can have items fraudulently added to them later.

7. **Investigate reports of lost prescriptions thoroughly**.

Community pharmacists in primary care are also being asked to be extra vigilant regarding pregabalin and to contact prescribers if they have concern regarding pregabalin use.

HSC Trusts have also been contacted to seek assistance in addressing these issues by

1. Ensuring regional guidance for neuropathic pain is followed (see attached)
2. Not recommending or initiating pregabalin first line for neuropathic pain in any setting including outpatient clinics and Emergency Departments, and
3. Removing pregabalin stock from Emergency Departments.

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. Misuse of pregabalin and gabapentin - Advice for prescribers - Jan 2015 http://primarycare.hscni.net/pdf/PregabalinAndGabapentinRiskOfMisuseAdviceHSCBWebVersion.pdf

3. Pregabalin - Why it's worthwhile to review prescribing - Medicines Management Newsletter Supplement July 2016http://niformulary.hscni.net/PrescribingNewsletters/MedicinesManagement/vol7/Vol7s5/Pages/default.aspx

4. Prescription Security - Guidelines http://www.medicinesgovernance.hscni.net/primary-care/gp-practice/prescription-security/

5. Fraudulent Attempts to Obtain Medicines for Patients Detained in Prison http://www.medicinesgovernance.hscni.net/download/primarycare/medicines_safety_advice_&_letters/150717FMRsPatientsInPrisonLetter.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