

High risk patient reviews – Gabapentinoids and opioids

Practices are asked to offer medication reviews for patients taking a combination of opioids and gabapentinoids (gabapentin and pregabalin) where the indication is pain, and review patients in-line with local and national guidance. The relevant NICE guidance for opioids can be found on the [Faculty of Pain Medicine's website](#).

The aim of this project is to review the risks of this combination of medicines when taken together, and to mitigate these risks by supporting patients, which may include reducing regimens, and where clinically suitable, discontinuing.

As part of this project, practices are asked to provide patients with information about the risks associated with co-prescribing gabapentinoids and opioids, and the benefits of reviewing and potentially reducing these medicines. This may include both verbal explanation and written information (for example text message or letter), depending on individual patient suitability and accessibility needs.

- [Opioid patient resource](#)
- [Gabapentinoid patient resource](#)
- [Chronic Pain – The Answers](#) – A Cornwall produced resource aimed at explaining to patients about chronic pain, and how to feel better living with pain through supported self-management
- PrescQIPP Bulletins:
 - [Reducing opioid prescribing in chronic pain](#)
 - [Neuropathic pain](#)

Searches have been provided for EMIS and SystmOne to identify patients who have been prescribed both a gabapentinoid and an opioid in the last 2 months. Clinicians should confirm the patient's current medication regimen during the medication review to ensure accuracy and assess ongoing appropriateness.

Background

The combination of co-prescription of opioids and gabapentinoids increases the risk of adverse events experienced by patients and increases the risk of opioid related death. Regular medication reviews are recommended to minimise these risks and are a part of the Care Quality Commission (CQC) inspection for safe medication usage.

Safety concerns around co-prescribing of these agents are highlighted from multiple sources:

- MHRA warnings on co-prescription of gabapentinoids and opioids – respiratory depression [DSU 2017](#), [DSU 2021](#).
- MHRA warnings regarding addiction, dependence, withdrawal and tolerance of gabapentinoids and other dependence forming medicines (DFMs), [DSU 2026](#).
- Gabapentin, opioids and the risk of opioid-related death – *1 of every 550 chronic opioid user dying within approximately 2.5 years of their first opioid prescription*. ([Kaplovitch et al, 2015](#))
- Patient safety concerns related to the use of gabapentinoids and opioids, include dependence, diversion and side effects ranging from drowsiness, dizziness, gait disturbances, falls, sexual dysfunction, and severe respiratory depression. ([FPM](#), [Muller 2024](#)).

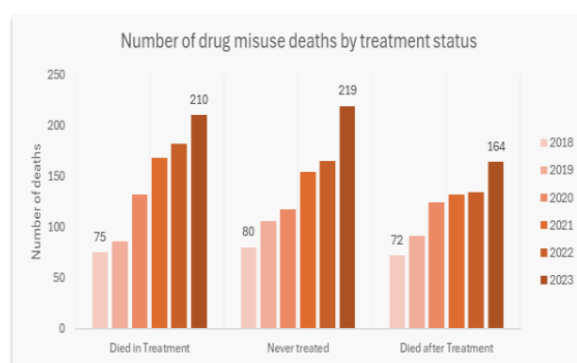
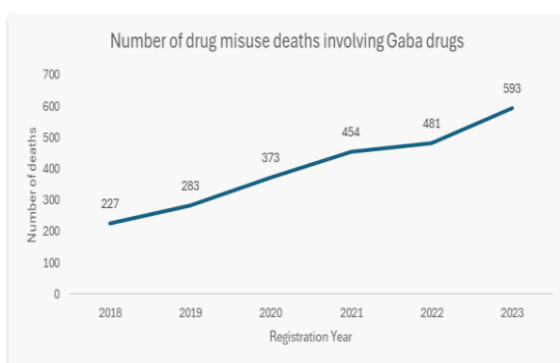
In November 2025, the Faculty of Pain Medicine revised the Opioids Aware guidance to **reduce** the recommended maximum oral morphine equivalent (OME) threshold **from 120mg to 90mg/day, with an ideal target of 50mg/day**. This change was based on new evidence highlighting increased harm at higher doses without proportional benefit. The Ardens searches to identify patients on high OME doses have been amended in-line with this guidance.

Local statistics

Across Cornwall there are an estimated 4,079 patients co-prescribed a gabapentinoid and an opioid (data from ePACT2 from September to November 2025).

In the 2024 [Drug Related Death report](#) for Cornwall and the Isles of Scilly, deaths involving gabapentinoid drugs for people in treatment have increased by over 161% in the past 5 years (2018 – 2023). Commonly prescribed opioids (codeine, morphine, oxycodone) were also implicated in the deaths of those in treatment. It is important patients are made aware of the harms of these medicines and are supported with safety netting and appropriate harm reduction.

Deaths involving Gaba drugs have increased substantially over the past five years particularly where the deaths have occurred during treatment



Payment

Practices will be paid £30 per review, up to a cap equal to 10p per listed patient. As a working example, a practice with 10,000 patients will be eligible for £1,000 payment and have a review cap of 34 patients.

Practices are asked to record each review using this [MS forms](#), which can be accessed via this link. To be eligible for payment for PMOS 26/27, all submissions need to be completed by 31 March 2027.

Caveats and limitations

Opioids and gabapentinoids, particularly when taken for long periods of time (>3 months), can cause harm when abruptly stopped or rapidly withdrawn. Balancing tapering speed with the risks of co-prescription requires a patient-centred clinical decision.

A clearly defined, structured patient-centred management plan for withdrawal, dose reduction and plans for the next review, should be undertaken with the patient to mitigate these risks.

Where gabapentinoids and opioids are working well at the lowest dose to maintain or improve function, dosage and usage of medication should be reviewed regularly at an agreed interval with the patient and clinician. Faculty of Pain medicine recognises a small proportion of patients may obtain good patient relief with opioids in the long-term, if the dose is able to be kept low.

Follow the links for more guidance for:

- [Opioid tapering](#)
- [Gabapentinoid tapering](#)

Please note – some patients may require longer tapering intervals than the guidance may suggest. The tapering schedule should be appropriate to the patient and agreed as part of the management plan.

Exclusions

This information sheet is intended to support the review of gabapentinoids when used for pain only and not intended to support reduction for other indications (for example, epilepsy, anxiety, opioid substitution therapy (OST)), though the combination of gabapentinoids and opioids for any indication will pose risks to patients. Advice and Guidance from [specialists](#) may be appropriate when undertaking reviews for more complex patients.

We encourage utilising clinical judgement to decide whether to review palliative and end of life patients on gabapentinoids and opioids.

Summary of recommendations

Review

- Assess usage of medicines – including non-prescribed medicines (e.g. OTC/herbal).
- Review indication, effectiveness, tolerability, adverse effects and adherence.
- Explain the risks/harms of the combination of gabapentinoids and opioids.
- Provide patient safety information in a suitable format (e.g. text/letter).
- Asking patients, '*What matters most to you?*' can help you and the patient agree on a shared decision on ongoing care and support.
- Consider [Biopsychosocial](#) reasons for pain when reviewing patients.
- Explanation of the evidence (NNT and NNH) may support patient discussions around choices to reduce.
- Consider renal function and licensed doses.

Recommendations

- Consider intermittent dose reductions (or drug holidays) to ensure ongoing prescribing is beneficial and clinically appropriate.
- Limit supply to 30 days or less per prescription.
- Consider taking steps to mitigate misuse and diversion.
- Ensure any episodes of overdose are coded.
- Consider multidisciplinary team (MDT) working, and referrals to onward services, for example social prescribers, [pain cafes](#), physiotherapists, [pain clinic](#), [WAWY](#).

Evidence summary

- NNT (number needed to treat) and NNH (numbers needed to harm) for gabapentinoids and opioids, when used appropriately for *neuropathic pain* ([Soliman 2025](#)).
 - NB: Fibromyalgia, lower back pain without sciatica and complex regional pain syndrome was excluded from the trials.

Medication	NNT	NNH
Gabapentinoids	8·9 (7·4-11·10)	26·2 (20·4-36·5)
Opioids	5·9 (4·1-10·7)	15·4 (10·8-24·0)

- Meta-analysis suggests gabapentinoids are no more effective than placebo for lower back pain ([Shanthanna et al 2017](#), [Giménez-Campos et al 2021](#)).
- NICE recommends not to initiate gabapentinoids for [managing sciatica](#), [lower back pain](#), [chronic primary pain and fibromyalgia](#) due to insufficient evidence.

Indications for dose reduction or discontinuation

- If the medicine is not providing useful pain relief.
- If the underlying pain condition resolves.
- If the patient develops intolerable side effects.
- The patient wishes to stop taking the medicine.

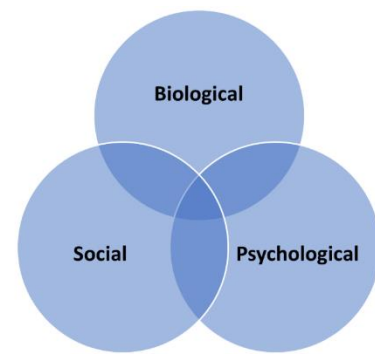
- If there is strong evidence of diversion

Special patient considerations

- Patients with the following past medical history may require increased support and specialist advice when reducing gabapentinoids.
 - A history of alcohol or other drug use or dependence. Be aware heavy users of alcohol may use it as a substitute for the drug being withdrawn.
 - Concurrent, severe medical or psychiatric disorder or personality disorder.
 - A history of drug withdrawal seizures - these generally occur in people who suddenly stop high doses of the drugs. Slow tapering is recommended for these individuals.
- Hyperbolic tapering may be beneficial for patients at lower doses where discontinuation is the aim. Lower doses of gabapentinoids may require smaller increments of dose reductions.
 - Maudsley advises against extending the dose interval (skipping doses) due to fluctuations in peak and trough levels.
 - With lower doses of gabapentinoids (<25mg pregabalin and <100mg gabapentin), using liquid formulations may support with further tapering.

Appendix 1 – Biopsychosocial model of pain

The [biopsychosocial model of pain](#) explains that pain emerges from a dynamic interplay between biological, psychological and social factors. It is important that affected patients are reviewed holistically, enabled with this mode, so prescribing changes are undertaken in a safe, patient-centred and evidence-based manner.



A structured review should consider the following domains:

Biological factors, for example:

- Indication for opioid and gabapentinoid (acute vs chronic pain, cancer vs non-cancer pain).
- Duration of medication use and current total daily dose.
- Analgesic benefit versus adverse effects (e.g. constipation, sedation, cognitive impairment etc.)
- Risk of dependence, tolerance, and/or opioid-induced hyperalgesia.
- Co-morbidities (renal/hepatic impairment, respiratory disease).
- Concomitant CNS depressants (e.g. benzodiazepines, z-drugs).

Psychological factors

- Patient beliefs about pain and reliance on opioid medication.
- Anxiety related to medication changes or fear of pain worsening.
- Mood disorders (e.g. depression, health anxiety), which may amplify pain perception.
- Coping strategies and previous experience of dose reduction or medication changes.

Social factors

- Impact of pain on function, employment, and activities of daily living.
- Social support, caring responsibilities, and safeguarding considerations.
- Risk of medication misuse, diversion, or stockpiling due to anxiety around shortages.
- Health literacy and ability to engage in shared decision-making.