Pain Management Formulary for Prisons:

The Formulary

for acute, persistent and neuropathic pain

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The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.

1 Introduction

The formulary is published as two documents that are available on the NHS England Health and Justice resources page *(link)*. They should be used together to embed the formulary into practice:

- The Formulary - this document contains the recommended medicines along with advice and clinical guidance links to support these choices. Quick reference versions are available at the end to support local use.

- Implementation Guide - the guide should be read alongside this formulary document and provides information about:

  - The scope and development of the formulary and who should use it.
  - How medicines fit into the pain care pathway versus alternative treatment.
  - The patient perspective on their experiences of current pain care in prisons.
  - Prescribing, reviewing and continuing pain care for people coming into prison, during their stay and on release or transfer to another prison.
  - Self-care and supporting self-management of pain by prisoners.
  - How to optimise safety when prescribing and using pain medicines for people in prison.

In addition to these publications, practical implementation tools and examples of good practice in managing pain in prisons will be collated and published in due course.

1.1 How the Formulary is structured

The formulary is divided into two sections:

- Acute and persistent pain
- Neuropathic pain

The formulary does not include the management of pain in palliative care or antispasmodics (including benzodiazepines) and pain management for specific clinical conditions such as gout or migraine. When selecting analgesia for these conditions, as advised by clinical guidelines, clinicians can still use the formulary to inform analgesic choices.

Each section is subdivided into:

- A brief summary about the section and links to the clinical evidence or guidance about managing the pain.
- A formulary key that describes the categories for the medicines shown in the formulary.
- An overview followed by specific sub-sections for different medicines types, their use, formulation and relevant clinical information.

1.2 Contents

1.3 Equality and Diversity

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it.

- given regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and in securing that services are provided in an integrated way where this might reduce health inequalities.

2 The Formulary

Acute and Persistent Pain

This formulary outlines a rational and evidence based approach to the pharmacological management of pain. Pain is usually described as acute or chronic and these terms describe the duration of the pain. Acute pain is usually of short duration and is associated with obvious tissue damage such as a sprain, fracture, operation or burn. The pain may be mild or severe and the intensity of pain is usually related to the degree of injury. Acute pain is usually self-limiting and medicines can be helpful for treating the pain as well as general measures (e.g. strapping a sprain).

Chronic or persistent pain is long-lasting (usually more than three months) and includes back pain, arthritis or pain associated with nerve damage e.g. stroke or HIV/AIDS. The pain can begin following an injury (but persists after the injury has healed) but sometimes it is not clear how persistent pain started. Persistent pain is not usually a sign of on-going tissue damage and the intensity of pain is not closely related to the degree of tissue injury. Persistent pain is difficult to treat and medicines are only partially effective and do not help all patients. Medicines should always be used as part of a wider treatment plan including advice on activity, and support in achieving improvements in quality of life.

N.B. The formulary excludes pain management guidance for palliative care and does not include advice on the pain management for specific clinical conditions such as gout, rheumatoid arthritis or migraine. Links to relevant national guidance on these conditions have been included where appropriate. However when selecting analgesia for these conditions clinicians can use the formulary to select analgesic choices.

This formulary should be read alongside the Prison Pain Management Formulary Implementation Guide *(link)*

Relevant NICE guidance and other resources relating to pain

The NICE Clinical Guideline for osteoarthritis (CG59) was updated as CG177 in February 2014 and did not consider pharmacological treatment options as stakeholder feedback during the consultation indicated that the draft recommendations, particularly in relation to paracetamol, would be of limited clinical application without a full review of evidence on the pharmacological management of osteoarthritis. In addition, there is an ongoing review by the MHRA (Medicines and Healthcare Products Regulatory Agency) of the safety of over-the-counter analgesics. NICE intend to commission a full review of evidence on the pharmacological management of osteoarthritis, which will start once the MHRA's review is completed, to inform a further guideline update.

At present, the original recommendations (from 2008) on the pharmacological management of osteoarthritis remain current advice. However, the Guideline Development Group (GDG) would like to draw attention to the findings of the evidence review on the effectiveness of paracetamol that was presented in the consultation version of CG177. The review identified reduced effectiveness of paracetamol in the management of osteoarthritis compared with what was previously thought. The GDG believes that this information should be taken into account in routine prescribing practice until the planned full review of evidence on the pharmacological management of osteoarthritis is published.

PHE, 2013, Managing Persistent Pain in Secure Settings	This guide from Public Health England (PHE) is an overview of best practice in managing persistent pain. It describes how this practice might be implemented in secure environments, including prisons. These complement the Royal College of GPs report 'Prescribing in Prisons' in 2011 and provide more details on use of pain medicines.

Dosage Equivalences

The current BNF has been used for all doses and dosage equivalences within the formulary. All dosage equivalences are determined in relation to the available products and available strengths.

Formulary Key

1st line formulary choice		Lowest risk of harm and misuse in prison
2nd line formulary choice		Also low risk use in prison, use when 1st line treatment is inappropriate or unsuccessful
3rd/4th line formulary choice		Only consider when other choices are inappropriate or unsuccessful, prescribe with caution
Limited use only		When all other options have failed, only use in the client group defined in the formulary
Avoid use and review patients		Considered inappropriate due to clinical or safety reasons

Abbreviations

C = capsule	MR = modified release	SR = sustained release
L = liquid	S = suspension	T = tablet

Overview Information

At first presentation, a sequential approach of simple analgesia and opioids for persistent pain is suggested.

On first presentation of acute pain analgesia should be prescribed in a stepwise manner. Full dose paracetamol should be prescribed and supplemented with non-steroidal drugs (NSAIDs) unless contraindicated.

If further pain relief is needed or if there is obvious severe tissue injury (e.g. major trauma, post-operative pain) tramadol or morphine may be added. For persistent pain, patients should be tried on full dose paracetamol with or without NSAIDs. Medications should be an adjunct to general measures such as advice about activity and sleep, physiotherapy and explanation that complete relief of symptoms is not a goal of therapy. Additional analgesia depends on the type of pain (see guidance). NB for persistent pain, reported pain intensity correlates poorly with the degree of tissue injury. The WHO analgesic ladder for cancer pain, in which strength and dose of medication is prescribed according to reported pain intensity is not an appropriate tool to guide prescribing for persistent pain.

Immediate release opioid preparations should be used for the management of acute pain as pain intensity changes daily and opioid requirements should reduce accordingly. If severe tissue injury persists for more than a few days it may be preferable to treat the patient with background sustained release opioid medication with immediate release preparations for breakthrough pain. Pain should be monitored several times daily.

If opioids are used as part of the treatment plan for persistent pain, sustained release preparations are preferable.

Simple analgesics and first-line NSAIDs				
PARACETAMOL		T/C 500mg S: 120mg/5ml, 250mg/5ml.	1g every 4-6 hours	Effective 1st line analgesic in acute pain. Ensure this is prescribed at maximum dose before escalating analgesia. Effervescent tablets have high sodium content (18.6mmol / tablet). Taking the maximum dose of paracetamol = 8g of sodium per day. Undertake local risk assessment before use.
Avoid use and review patients				
NEFOPAM		A Cochrane review suggests no evidence of efficacy. Affects the results of mandatory drug testing (MDT) with benzodiazepines. Can't be used in patients with seizures, not recommended to be taken with antidepressants. It is acknowledged that previous guidance and practice in prisons has been to advise the use of nefopam prior to initiating opioids or to support the clinical need for analgesia. However the clinical evidence for its use has changed, questioning its efficacy and thus its use can no longer be recommended. Cochrane review		
Relevant safety information and NICE guidance and other resources relating to NSAIDs.				
Where possible, co-prescribing NSAIDs with full dose paracetamol is advisable before considering stronger analgesia.				MHRA NSAID guidance

Gastroprotection: Use omeprazole 20mg capsules once daily or lansoprazole 15mg capsules once daily for GI prophylaxis in all long-term users of NSAIDs.				Clinical Knowledge Summary guidance for use of PPIs in gastroprotection
Management of osteoarthritis - Clinical Knowledge Summary				http://cks.nice.org.uk/osteoarthritis
The management of rheumatoid arthritis in adults, NICE Clinical Guideline 79				NICE Clinical Guideline 79
IBUPROFEN		T: 200mg, 400mg, 600mg	1.2g daily in 3-4 divided doses	In line with MHRA guidance - prescribe at the lowest possible dose for the shortest period of time. Ibuprofen has lowest GI risk of standard NSAIDs. Daily doses less than 1200mg are not associated with increased thrombotic risk. Can be used for migraine and dysmenorrhoea.
		L: 100mg/5ml	As above	
		T: 800mg MR	800mg-1.6g once daily	
NAPROXEN		T: 250mg, 500mg	500mg-1g daily in 1-2 divided doses	Doses of less than 1g daily are not associated with increased thrombotic risk. Longer duration of action than ibuprofen. For use in mild to moderate pain. Can be used for dysmenorrhoea.
OTHER NSAIDs AS PER LOCAL PRIMARY CARE FORMULARY				Use a 2nd line NSAID if ibuprofen/naproxen not effective or alternative needed for specific indications.
Avoid use and review patients				
DICLOFENAC		To be avoided; injectable formulation can be used for short term, severe, acute episodes only.		European Medicines Agency diclofenac advice
RUBEFACIENTS AND TOPICAL ANTIRHEUMATICS		All are licensed for short-term use only. The evidence available does not support the use of topical rubifacients in acute or chronic musculoskeletal pain. In addition some products e.g. Deep Heat, cause harm if in contact with mucous membranes and may prove a safety risk in prisons.		

Topical NSAIDs and CAPSAICIN

Caution: To be applied with gentle massage only. Not for use with occlusive dressings.

Photosensitivity: Excessive exposure of the treated area to sunlight may possibly cause photosensitivity. Patients using preparations containing ketoprofen should not expose the treated area to sunbeds or sunlight during, and for two weeks after stopping treatment.

Prescribe appropriate quantity: Topical application of large amounts can result in systemic effects including hypersensitivity & asthma.

IBUPROFEN		Gel 5% & 10%	Three times daily	PRESCRIBE BY MOST COST EFECTIVE BRAND.
PIROXICAM		Gel 0.5%	Up to four times daily	30g, 60g or 112g
ALGESAL®		Diethylamine salicylate cream 10%	Three times daily	50g or 100g

OTHER TOPICAL NSAIDs AS PER LOCAL PRIMARY CARE FORMULARY

Avoid use and review patients

CAPSAICIN		Cream; not advisable for use in prison setting due to potential harm on contact with the mucous membranes (see SPC). Patches; not recommended by NICE CG 173 except under specialist care Capsaicin cream SPC

Opioid analgesics

Opioid Resources

The British Pain Society, Opioids for persistent pain - Good Practice, June 2010 Link	February 2014 Update: The review and update of the British Pain Society (BPS) publication will be encompassed in a new publication addressing all aspects of opioid use and misuse. In the interim the current content of 'Opioids for persistent pain' has been reviewed and remains accurate.

Opioid dependence and addiction - BPS statement

The safety and efficacy of opioids in the long term is uncertain as is the propensity for these drugs to cause problems of tolerance, dependence and addiction. The benefits of opioid treatment for the patient must be balanced against burdens of long term use as therapy for persistent pain may need to be continued for months or years. Patients with a current or past history of substance misuse or with a comorbid non-substance misuse psychiatric diagnosis may be more likely to develop problems with opioid use. Opioid treatment for these patients should be closely and collaboratively monitored by specialists in pain management and/or addiction medicine. Patients receiving methadone treatment for addiction may report pain that emerges as the dose of methadone is tapered. These patients should be assessed for suitability for opioid therapy for pain. If opioid treatment of pain is indicated, and the preferred first line opioid (i.e. morphine) is ineffective, consider using the existing dose of methadone administered in divided doses 12 hourly. Opioid therapy is poorly effective in the management of persistent pain and patients should be monitored regularly to assess the effectiveness of treatment, in particular, patients should report improvement in function with opioid therapy. Opioids should only be prescribed as part of a wider treatment plan including non-pharmacological interventions such as physiotherapy and advice about sleep and activity. Complete relief of symptoms is not a realistic goal of treatment.

NPSA resources relating to pain

This Rapid Response Report alerts all healthcare professionals prescribing, dispensing or administering opioid medicines to the risks of patients receiving unsafe doses.	Link

Other considerations

In-possession (IP) vs. not in-possession (not IP): Schedule 2 and 3 controlled drugs should not be routinely provided in-possession as per national guidance. For non-scheduled opioids a local decision is needed based on local risks and access to supervised administration for three and four times daily doses. It is recommended that where in-possession is supported for these medicines, that this is restricted to a maximum of **weekly in-possession** and that there are additional processes in place to confirm adherence to identify potential diversion or abuse.

Formulations: For all opioids tablet formulations are preferred as there is less risk of diversion. Where sustained release preparations are available these are preferred to support not in-possession administration. The use of liquid preparations is usually limited to individual cases. Careful risk assessment for wider use should take into account the cost of the liquid preparation as well as operational factors.

First line opioids

During titration/adjustment to the most effective dose to relieve pain it is useful to prescribe the chosen first line opioid separately to paracetamol unless there is a specific reason to use a combination. Conversion to a combination product with paracetamol may encourage adherence once an effective dose is established. The most cost effective option is prescribing oral first line opioids separately to paracetamol.

First Choice				
CODEINE		T: 15mg, 30mg L: 25mg/5ml	30mg - 60mg every four hours when necessary to a maximum of 240mg daily.	The metabolite of codeine is morphine which affects the results of mandatory drug testing (MDT). MHRA Codeine restrictions
Second Choice				
COMPOUND ANALGESICS				
Avoid combinations where possible during the initial stages of opioid treatment as doses are easier to titrate/adjust if the drugs are prescribed separately. Use cost effective generic preparations where possible.				
CO-CODAMOL 8/500		T: 8mg codeine, 500mg paracetamol	One or two tablets to be taken up to four times daily as required.	Lower dose (8/500) may be sufficient in frail patients and as a starting dose for opioid naïve patients. Can be requested by prisoners to mask illicit opioid use - will still test positive for opioids following MDT. Clinical Knowledge Summary - Combining analgesics
CO-CODAMOL 30/500		T: 30mg codeine, 500mg paracetamol		
EFFERVESCENT PREPARATIONS		Local risk assessment determines the place of effervescent preparations in care pathways. These can be helpful for reducing diversion risk as well as supporting patients who are unable to swallow solid dosage forms. Consideration should be given to the impact of supervised administration as extra time will be taken as the tablets dissolve.		

Limited use only				
DIHYDROCODEINE (DHC) SUSTAINED RELEASE ONLY	L	SR tablets: 60mg, 90mg, 120mg	60mg -120mg every twelve hours	**Reserved for patients where opioid is required and not IP and in other clinical circumstances where codeine is not suitable.** Limit maximum dose to 120mg to 180mg daily. Higher doses offer some additional pain relief but may cause more nausea and vomiting. 120mg to 180mg daily is equivalent to 12mg to 18mg oral morphine daily. **Additional caution in those with opioid addiction.**
Avoid use and review patients				
CO-CODAMOL 15/500	X	This formulation is not recommended as it is not a cost effective choice.		
METHADONE	X	Not recommended for pain in secure environments except when pain emerges when methadone dose is reduced as part of substance misuse dose tapering (see notes above). Review alternative choice of analgesia for patients. A Cochrane review found very limited evidence of the effectiveness of methadone for chronic non-cancer pain. No conclusions can be made regarding differences in effectiveness or side effects between methadone, placebo, other opioids, or other treatments for non-cancer pain. Cochrane review		

Second line opioids

It is not recommended that any two opioids be prescribed together.
It is unlikely that if a particular opioid has failed, that another will work. This is supported by a Cochrane review of opioid rotation which disputes previous evidence that prescribing another opioid will be effective when a previous opioid has failed. Cochrane review

There is no evidence that any pure opioid agonist provides improved efficacy and safety compared to morphine.
NOTE: Good Practice is to prescribe the most cost effective morphine brand according to the local primary care formulary.

CONTROLLED DRUG PRESCRIBING - Department of Health Guidance 2006 - in general the prescriptions for controlled drugs in Schedule 2, 3 and 4 should be limited to 30 days' treatment and not prescribed as repeat prescriptions.

Tramadol is a strong opioid. In addition to mu-opioid receptor agonist action it also has action on CNS monoamine neurotransmitters. It is a Schedule 3 controlled drug but is exempt from Safe Custody requirements. Tramadol is the only opioid with long term efficacy data. It is important however, for prescribers to take account of the potential risk in the event that prescribed tramadol is used in conjunction with additional illicitly acquired substances.				
NHS England guidance on handling of tramadol in secure environments, 2014				Link
First Choice				
TRAMADOL - SUSTAINED RELEASE PRODUCTS ONLY	✓	24 hourly preparations T: 100mg, 150mg, 200mg, 300mg, 400mg 12 hourly preparations C: 50 mg, 100mg, 150mg, 200mg T: 100mg, 150mg, 200mg	100mg - 150 mg once daily, increased if necessary; usual maximum is 400mg once daily. 50mg–100 mg twice daily increased if necessary to 150mg-200mg twice daily; total of more than 400mg daily not usually required.	Long-acting preparations recommended for persistent pain and should be administered under supervision (not in-possession). Dose conversions vary. 400mg daily dose of tramadol is approximately equivalent to 40mg-80mg of oral morphine. (NHS Wales Opiate conversion doses 2010) **Where facilities don't allow twice daily dosing, use the 24 hr preparation**.
Second Choice				
MORPHINE	✓	C: 30mg, 60mg, 90mg, 120mg, 150mg, 200mg T: (immediate release) 10mg, 20mg & 50mg L: 10mg / 5 ml	Once daily, every 24 hours For acute pain use. For acute pain use.	**STOP weak opioids prior to addition of strong opioid as the effect of taking together is likely to be additive. Patients who have received oral 120mg to 180mg DHC OR codeine daily can be initiated on 30mg once daily modified release capsules.** Immediate release products are reserved for acute pain use only.

MORPHINE (Contd)		Titration must be slow with regular review. Maintain paracetamol / NSAIDs at maximum dose. For persistent pain long acting preparations should be used. A total daily dose of 60mg of morphine with NO response suggests pain is unlikely to be opioid responsive. Doses of greater than 120mg oral morphine equivalent should not be used. **The patient should be closely monitored for pain relief as well as for side effects especially respiratory depression and constipation. Patients may require a regular laxative.**	
Avoid use and review patients			
OXYCODONE	X	There is no evidence that any opioid produces superior efficacy or has fewer side effects than morphine.	
TRANSDERMAL & FAST ACTING OPIOID PREPARATIONS (BUPRENORPHINE, FENTANYL)	X	There is no evidence that any opioid produces superior efficacy or has fewer side effects than morphine. Transdermal administration of opioids does not confer advantages compared to the oral route except for specific situations when managing pain in patients who are unable to swallow. Transdermal patches are very divertible and there is a large risk of overdose in opioid naive patients. This clinical risk outweighs any operational advantage in reducing medicines administration sessions when using these formulations.	
		CQC: Safer use of fentanyl and buprenorphine transdermal patches	MTRAC Fentanyl Transdermal Patches in non-cancer pain 2012

Management of Neuropathic Pain

Relevant NICE guidance and other resources relating to neuropathic pain

Key points: Medications are the best way to treat neuropathic pain but fewer than a third of patients will respond to any given drug. Different classes of drug have distinct and relevant mechanisms of action, so if the first class tried does not work it is helpful to stop it and try an alternative.

NICE, Neuropathic pain: the pharmacological management of neuropathic pain in adults in non-specialist settings - CG173	
PrescQIPP - Pregabalin in neuropathic pain (2014)	
PHE 2013 - Managing Persistent Pain in Secure Settings	This guidance includes a section on the management of neuropathic pain. The content of this formulary reflects this.
PHE 2014 - Advice for prescribers on the risk of the misuse of pregabalin and gabapentin	

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Abbreviations		
C = capsule L = liquid	MR = modified release S = suspension	SR = sustained release T = tablet

First Choice				
AMITRIPTYLINE		T: 10mg, 25mg, 50mg	Usual starting dose is 10mg in the evening. Maintenance dose to achieve response is 50 - 75mg in the evening.	Response rarely achieved at dose <50mg. Use of amitriptyline doses above 75mg daily is usually under specialist supervision.
Second Choice				
DULOXETINE		C: 30mg, 60mg	Usual starting dose is 30-60mg daily. Max dose 120mg daily.	
Third Choice				
CARBAMAZEPINE		T: 100mg, 200mg, 400mg.	Initially 100mg 1-2 times daily, increased gradually according to response. Usual dose 200mg 3-4 times daily.	To be offered as initial treatment for trigeminal neuralgia. Carbamazepine reduces the plasma concentration of methadone; carbamazepine reduces the effects of tramadol. Doses of methadone and tramadol need to be adjusted to clinical requirement. Carbamazepine interacts with many medicines, clinicians should refer to the SPC for details. Carbamazepine SPC
Limited Use Only				
NORTRIPTYLINE		T: 10mg, 25mg, 50mg	Usual starting dose is 10mg in the evening. Maintenance dose to achieve response is 50 - 75mg in the evening.	Current costs are prohibitive in recommending nortriptyline as a second line treatment and it has been removed from NICE guidance. It may be useful in limited cases where sedation with other tricyclic antidepressants is a problem. Response rarely achieved at dose <50mg. Use of nortriptyline doses above 75mg daily is usually under specialist supervision. Drug Tariff

Relevant safety and other information relating to gabapentin and pregabalin				
Gabapentin and pregabalin should be prescribed for their licenced indications only. Evidence in secure environments suggests there is significant prescribing of gabapentin and pregabalin off-label. Secure environment pregabalin & gabapentin audit				
Due to interactions with substance misuse and other CNS medicines and risks of misuse in people with a history of substance misuse, individual risks and benefits that should be carefully taken into consideration when prescribing and monitoring outcomes from these medicines. They should be used on a case by case basis. Less harmful, alternative drugs can often be first-line treatments for the indicated conditions for which pregabalin and gabapentin are now used, and may be tried preferentially in higher risk settings or in patients who may be more likely to be harmed by the drugs.				
PHE 2014 Advice for prescribers on the risk of the misuse of pregabalin and gabapentin				
GABAPENTIN		C: 300mg T: 600mg L: 50mg/ml	Usual starting dose is 300mg at night - titrate to achieve target dose of 1.8g – 2.7g daily in divided doses. Maximum is 3.6g daily.	Dosage requires to be adjusted in renal impairment - see BNF for full guidance. Avoid abrupt withdrawal if treatment not tolerated. Liquid may be considered according to local CCG formulary for exceptional use. Evidence from usage in the USA suggests that twice daily dosing with gabapaentin can be used unless documented neuropathic pain is unresponsive to optimal twice daily dosing. Evidence from USA
PREGABALIN (Lyrica®)		C: 50mg, 75mg, 100mg, 150mg, 200mg, 225mg, 300mg.	Usual starting dose is 150mg/day (in two divided doses) with **maximum dose** 600mg/day (in two divided doses).	A lower starting dose may be more appropriate for some people. All strengths are the same price - **please dose optimise** where possible. **For current patients please review prescribing and consider a change to gabapentin as more cost effective. See PrescQIPP bulletin 50 for further details of switching.** PresQIPP Bulletin 50 - Neuropathic pain: Pregabalin and gabapentin prescribing.

TRAMADOL - SUSTAINED RELEASE PRODUCTS ONLY		T: 100mg, 150mg, 200mg, 300mg, 400mg	Usual dose 100mg-150mg once daily, increased if necessary; usual maximum of 400mg once daily not usually required.	Long acting preparations recommended for persistent pain and should be administered under supervision (not in-possession). Neuropathic pain may respond to opioid analgesics (BNF). **Consider only for refractory cases of neuropathic pain of confirmed origin.**
Avoid use and review patients				
LIDOCAINE PATCHES		Lidocaine patches are for specialist use only.		
BUPRENORPHINE PATCHES		A recent Cochrane review found there is no evidence to support or refute the suggestion that buprenorphine has any efficacy in any neuropathic pain condition. People prescribed buprenorphine patches for neuropathic pain should be reviewed.		

3 Quick Reference Versions

Acute and Persistent Pain		
Simple Analgesics and NSAIDs		
Paracetamol		Maximise dose before changing
Ibuprofen		Use omeprazole 20mg capsules once daily or lansoprazole 15mg capsules once daily for GI prophylaxis in all long-term users.
Naproxen		
Other NSAIDs as per CCG formulary		
Topical Analgesics		
Ibuprofen		Prescribe appropriate quantity: topical application of large amounts can result in systemic effects.
Piroxicam		
Algesal®		
Avoid and Review		
Diclofenac (oral)		Safety concerns
Nefopam		Evidence does not support use
Rubifacients and topical antirheumatics		Evidence does not support use
Capsaicin topical		Safety concerns; specialist only
First Line Opioids		
Codeine		Prescribe the chosen first line opioid separately to paracetamol unless there is a specific reason to use a combination.
Co-codamol 8/500mg		Lower dose may be sufficient in frail patients & as a starting dose for opioid naïve patients
Co-codamol 30/500mg		
Effervescent products		Beware of high salt content
Limited Use Only		
Dihydrocodeine sustained release		Reserved for patients where opioid is required and not IP and in other clinical circumstances where codeine is not suitable.
Avoid and Review		
Co-codamol 15/500mg		Not a cost effective choice
Methadone		Restricted for pain emerging during substance misuse dose reduction.
Second Line Opioids		
Tramadol sustained release only (CD)		Use once daily preparations
Morphine sustained release only (CD)		Closely monitor for pain relief and side effects (respiratory depression and constipation).
Avoid and Review		
Oxycodone		No benefit over morphine
Transdermal patches and fast acting preparations of fentanyl and buprenorphine		Clinical risk outweighs any operational advantage in reducing medicines administration sessions.

Management of Neuropathic Pain		
Medications are the best way to treat neuropathic pain **but fewer than a third of patients will respond to any given drug.** Different classes of drug have distinct and relevant mechanisms of action, so if the first class tried does not work it is helpful to stop it and try an alternative		
Amitriptyline		Response rarely achieved at dose <50mg. Use of amitriptyline doses above 75mg daily is usually under specialist supervision.
Duloxetine		Usual starting dose is 30-60mg daily.
Carbamazepine		Carbamazepine interacts with many medicines, clinicians should refer to the SPC for details. Carbamazepine SPC
Limited Use Only		
Nortriptyline		Not a cost effective choice
Gabapentin		Gabapentin and pregabalin should be prescribed for their licenced indications only. High risk for trading and diversion.
Pregabalin (Lyrica)		
Tramadol sustained release		Consider only for refractory cases of neuropathic pain of confirmed origin.
Avoid and Review Use		
Lidocaine patches		Specialist use only
Buprenorphine patches		No evidence for use

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