DEPRESCRIBING

Deprescribing is an important element of medicines optimisation and involves identifying the point at which drugs are no longer providing a worthwhile benefit (and may actually be causing harm).

The purpose of this supplement is to highlight therapeutic areas that could be targeted for switching to a more cost-effective product or formulation or a medication review, with the possibility of stopping or reducing the medicine(s). This list is not exhaustive. Deprescribing should take account of the following:

- Deprescribe where clinically appropriate
- Use NI Formulary Choices
- Prescribe generic medicines as appropriate
- Use cost-effective choices, cost-effective doses and cost-effective formulations
- Stop use of medicines on Stop List
- Reduce use of medicines on Limited List
- Medication Review – Primary Care Intranet (hscni.net)
- Consider non-pharmacological strategies

Therapeutic Area	Drugs	Actions	Resources
GI System	Proton Pump Inhibitors	• Use cost effective PPIs (omeprazole capsules/ lansoprazole capsules) • Do not routinely prescribe esomeprazole. If esomeprazole required use generic capsules rather than tablets (do not prescribe brand, e.g. Nexium®) • Dispersible and orodispersible PPIs should be reserved for children and infants, people with dysphagia, those with enteral feeding tubes • Liquids should be reserved for patients with narrow feeding tubes (≤ 6Fr or jejunal extension in situ), or in paediatrics where a dose of <5mg is indicated. • If liquid required, use licensed omeprazole suspension- avoid use of specials • Long term prescribing should be reviewed. Resources are available to assist with review	Proton Pump Inhibitors (PPI) Proton pump inhibitors NI Formulary https://primarycare.hscni.net/wp-content/uploads/2017/03/attachment-5-ppis-long-term-safety-and-gastroprotection-deprescribing-algorithm-adults-20.pdf Heartburn and Reflux | NI Formulary (hscni.net) https://niformulary.hscni.net/patient-area/review-of-medication-for-heartburn-reflux/reflux-in-children-gord/

	H2 antagonists	• Prescribers should review **all** patients prescribed famotidine for continued need. Where medication is still found to be appropriate, consider a switch to either omeprazole or lansoprazole capsules • Prescribers should review **all patients co-prescribed famotidine and a PPI for periods longer than 8 weeks**. Patients should be advised to step down and stop famotidine if refractory symptoms have resolved.	
	Antispasmodics	• Do not prescribe dicycloverine (high ACB) – for existing patients review and stop/switch • All antispasmodics should be kept under review and stopped if no therapeutic benefit	1.2 Antispasmodics and other drugs altering gut motility | NI Formulary (hscni.net) https://primarycare.hscni.net/download/DocLibrary/Pharmacy/Clinical/Medication%20Review/Anticholinergic-burden-medication-review-leaflet-fv.pdf

	Laxatives	• Counsel patients re lifestyle and diet – • Laxatives should not routinely be prescribed longterm Refer to Prescripp constipation guidance • Review patients currently prescribed naloxegol for opioid induced constipation (OIC) and ensure they are not using concurrent laxative therapy. • Review naloxegol in patients who have not had OIC managed as per NICE recommendations above. • Ensure patients who are on opioid treatment are offered dietary and lifestyle advice. Co-prescribe laxatives as per NICE recommendations from the outset	https://primarycare.hscni.net/download/DocLibrary/Pharmacy/Clinical/Gastrointestinal/constipation_management_and_review/SPPG-constipation-patient-information-leaflet-.pdf https://primarycare.hscni.net/download/DocLibrary/Pharmacy/Clinical/Gastrointestinal/constipation_management_and_review/272i.-Constipation-2.0-NI.pdf
	Deodorants for stoma	• Do not prescribe spray deodorants for patients with a stoma as per PrescQIPPguidance.	Bulletin 338. Stoma | PrescQIPP C.I.C Stop and Limited Evidence List | NI Formulary (hscni.net)

	Probiotics	• Do not prescribe probiotics Patients should be counselled that there is a lack of evidence supporting a benefit of probiotics in any indication. Should they wish to trial, they should be advised to purchase probiotics	Prescribing of Probiotics – Primary Care Intranet (hscni.net) Prescribing Stop List | NI Formulary (hscni.net)
Respiratory	SABA inhalers	• Prescribing three or more SABA inhalers per year is associated with an increased risk of severe exacerbations and mortality, and reflects very poorly controlled asthma. Asthma patients prescribed three or more SABA inhalers in the previous 12 months should be prioritised for review.	National Review of Asthma Deaths | RCP London
	ICS/LABA inhalers	• Cost effective Fluticasone/salmeterol combination inhalers currently are Combisal® or Avenor®	3.2.2 Compound ICS/LABA preparations – [asthma] | NI Formulary (hscni.net)

	LAMA DPIs	• Cost effective Tiotropium dry powder inhalers currently are Acopair® or Tiogiva®	bronchodilators
	Mucolytics	• Mucolytics must only be prescribed to COPD patients with chronic cough productive of sputum. **Discontinue after 4 weeks if there is no symptom improvement.**	PrescQIPP COPD bulletin 2022
	Non-sedating Antihistamines	• Recommend purchase of antihistamines for hayfever • If prescribing is necessary use the NI Formulary cost-effective choices: cetirizine tablets or loratadine tablets • Liquid antihistamines should be reserved for very young patients who can't swallow tablets	NI medicines management hay fever supplement May 2024 Cost effective choice list How to give medicines: tablets – Medicines For Children

	Dymista®	• Dymista® should not be used as a first-line treatment choice. If refractory symptoms remain despite regular use of INCS, check compliance and technique. • Review and switch to CEC steroid nasal spray (beclometasone/ mometasone) with or without oral antihistamine. • Do not co-prescribe Dymista® with an oral antihistamine	NI Medicines Management hayfever supplement May 2024
	Adrenaline (stock requisition forms HS21S)	• Adrenaline auto-injectors (AAIs) should not be requisitioned for healthcare professional use • Adrenaline 1:1000 (1mg/ml) x 1ml ampoules are the recommended preparation to be held and used for management of anaphylaxis by healthcare professionals	Green book -chapter 8 Letter: Adrenaline use in Primary Care October 2023
Central Nervous System	Hypnotics and anxiolytics	• Do not prescribe anxiolytics or hypnotics routinely • Review long term use • Recommend non-drug options first e.g. good sleep guide. • Prescribe only if necessary and for the shortest time possible	Mental Health – Primary Care Intranet (hscni.net) Mental Health (including sleep and relaxation) | NI Formulary (hscni.net)
	Melatonin **(adults)**	• Do not prescribe melatonin for Jet Lag • Review melatonin and deprescribe where clinically appropriate. A deprescribing algorithm to support this review is available from PrescQIPP. **If the patient is under specialist review (e.g. psychiatry, learning disability, memory team, neurology) seek further advice**	https://www.prescqipp.info/media/zmzojern/attachment-5-deprescribing-melatonin-2-2.docx

	Analgesics	Chronic non-malignant pain: follow NICE guidance Do not routinely prescribe • Lidocaine patches	Pain Primary Care Intranet (hscni.net) NI Formulary Chronic Non-Malignant Pain

		• Strong opioids / weak opioids / combination analgesics • Gabapentinoids Remember: • Justify reasons if prescribing and stop if no benefit (pain reduction, improved sleep / function / psychological wellbeing) after appropriate trial. • Gabapentinoids and opioids require **slow reduction**.	NICE: NG 193, CG 173, NG215 Prescribing Newsletter articles • NICE Opioid Recommendations (Jan 23) • Opioid Deprescribing -Top Tips (Oct 23) • Reducing Opioids – Safety Messages and Community Pain Support Programmes (May24) • Coroner alert – Oxycodone and pregabalin toxicity (Jun24) • Gabapentinoid deprescribing (Feb24) Prescqipp Bulletin 336. Reducing opioid prescribing in chronic pain PrescQIPP bulletin available: https://www.prescqipp.info/our-resources/bulletins/bulletin-324-combination-analgesics/

	Antiepileptics	Review patients on branded levetiracetam or lacosamide to consider switching to the generic, on a case-by-case basis and with patient agreement. • Initiate all Levetiracetam and lacosamide new starts on the generic, even if the brand name is used in hospital correspondence..	Generics – Primary Care Intranet (hscni.net)

		• Use the most cost-effective strength of lamotrigine/Lamictal to achieve the required dose. This may need reviewed periodically as the patient's dose is tapered up.	Newsletter : https://niformulary.hscni.net/download/176/volume-12-2021/9703/lamotrigine-supplement-feb-2021 Patient Leaflet : https://niformulary.hscni.net/patient-area/epilepsy-lamotrigine-information/ Cost Effective Choices list: https://niformulary.hscni.net/prescribing-newsletters/cost-effective-choices/

	Antidepressants	• Review prescribing of antidepressant therapy for the management of depression in adults to ensure prescribing is in line with NICE CG 222. Deprescribe where considered clinically appropriate and in line with NICE CG 215 • NICE CG 215 medicines associated with dependence or withdrawal symptoms advises using a shared decision making approach to discuss the deprescribing of antidepressants with the patient. Deprescribing in practice means, reducing the dose at a pace that is tolerable for the patient, which for some patients can mean tapering for several months or longer. • Do not prescribe trimipramine or dosulepin for any new patient. - review existing patients for suitability to switching to an alternative antidepressant or stopping if clinically appropriate, in line with guidance. This may require consultation with a specialist.	Deprescribing of antidepressants for depression and anxiety – SPS - Specialist Pharmacy Service – The first stop for professional medicines advice Prescribing Stop List | NI Formulary (hscni.net) Bulletin 310: Dosulepin (prescqipp.info) Bulletin 311: Trimipramine (prescqipp.info)
Infection	Antimicrobials/ Antibiotics	Do not prescribe an immediate antibiotic for common infections (viral / self-limiting conditions such as coughs, colds and sore throats) follow NICE guidance, provide advice on duration of illness, self-care (available OTC) and safety netting	Antibiotic and diagnostic quick reference tools: Summary of antimicrobial prescribing guidance - managing common infections (rcgp.org.uk)

			TARGET Learning resources for prescribers TARGET Respiratory Tract Resource suite (including audits and patient leaflets) GPNI Antimicrobial update: Prescribing in a Post-COVID19 & Strepocolypse World Antimicrobials/Antibiotics – Primary Care Intranet (hscni.net) Antimicrobial stewardship HUB | PrescQIPP C.I.C
	Long-term UTI prophylaxis	Antibiotic prophylaxis for recurrent UTI: review at 6 months with a view to stopping as per NICE guidance	NI Formulary/ Microguide Recurrent UTIs – Adults Overview | Urinary tract infection (recurrent): antimicrobial prescribing | Guidance | NICE Nitrofurantoin: reminder of the risks of pulmonary and hepatic adverse drug reactions - GOV.UK (www.gov.uk)

			PRESCQIPP Bulletin 277: Prevention, recognition and management of UTIs TARGET Treating Your Infection UTI leaflet FOR OLDER ADULTS and those who care for them
Endocrine	GLP1 inhibitors	• Review ongoing need for GLP1 inhibitors under NICE 'stopping rules' and deprescribe where appropriate	Diabetes – Primary Care Intranet (hscni.net) (GLP1 supplement May 2023)
	DPP4 inhibitors (Gliptins)	• De prescribe DPP4 inhibitors Gliptins where co-prescribed with a GLP1 inhibitor as the combination is unlikely to provide synergistic effects beyond monotherapy with either agent.	GLP-1 Receptor Agonists | NI Formulary (hscni.net)
	Diabetes drugs	• Deprescribing in the frail elderly with diabetes	Diabetes-Supplement May 2024 | NI Formulary (hscni.net) (see 'deprescribing in elderly article')
	Drugs used for treatment of hypoglycaemia	• Use most cost-effective glucose 40% gel (Rapilose®) for treatment of hypoglycaemia • Do not prescribe glucose tablets or glucose juice shots	Prescribing Stop List | NI Formulary (hscni.net)
	Consumables used for diabetes	• Review quantity prescribed of Blood Glucose Monitoring Strips • Do not prescribe insulin safety needles	Diabetes – Primary Care Intranet (hscni.net)

	Drugs for osteoporosis	• Do not prescribe bisphosphonates for more than 10 years and review ongoing need after 5 years • Do not prescribe generic Vitamin D specials – prescribe brands as noted in the NI formulary • Do not prescribe generic calcium and Vitamin D products, prescribe a brand as noted in the NI formulary	Osteoporosis – Primary Care Intranet (hscni.net)
	Drugs for hypothyroidism	• Do not prescribe Levothyroxine liquid unless the patient has swallowing difficulties or there is a definite indication for a liquid preparation • Liothyronine should only be used on the recommendation of a Health Service endocrine specialist in secondary care; prescribers in primary care should not initiate liothyronine. • Where prescribing is appropriate use the more cost-effective capsules instead of tablets	Thyroid -Primary Care Intranet (hscni.net)

	Drugs for hyperthyroidism	• Carbimazole should be initiated under specialist advice. For new patients, doses should be prescribed in multiples of 5mg as appropriate. For existing patients where a higher tablet burden is manageable practices should consider changing doses to multiples of 5mg Propylthiouracil may be an alternative for patients who suffer sensitivity reactions to carbimazole. For new patients, doses should be prescribed in multiples of 50mg as appropriate. For existing patients where a higher tablet burden is manageable consider changing doses to multiples of 50mg tablets	Hyperthyroid NI Formulary

Gynaecology and Urinary-tract Disorders	Drugs for urinary frequency, enuresis & incontinence	• Do not prescribe long term bladder anticholinergics unless there are clear benefits In line with NICE NG123
		  ○ Review female patients >65 years on oxybutynin
		  ○ Review patients with dementia and urinary incontinence NG97
		
		Review female patients prescribed flavoxate, propantheline and imipramine for UI/OAB
			Contraception, Gynae and Urinary Disorders – Primary Care Intranet (hscni.net)
			
			Anticholinergic Burden | NI Formulary (hscni.net)

	Female sex hormones	• Do not prescribe in nursing home patients with advanced/end stage dementia • Review patients on HRT and discuss individual benefits and risks of short term (up to 5 years) and longer-term use (e.g. VTE, CVD, type 2 diabetes, breast cancer, osteoporosis, dementia) NICE NG123	Contraception, Gynae and Urinary Disorders – Primary Care Intranet (hscni.net) 268. IMPACT 2021 2.0 (prescqipp.info) (*IMPACT tool requires free registration. Instructions here*) Bulletin 299: Menopause | PrescQIPP C.I.C

	Preparations for vaginal & vulval infections	• Encourage self care • Referral to Pharmacy First Everyday Health Conditions where appropriate	Health conditions A to Z | nidirect
	Alpha blockers for urinary retention in men	• Do not prescribe two alpha blockers concurrently	PMMT newsletter article
Nutrition	Infant formula	• Do not prescribe infant formula for infants greater than 12 months (except under specialist direction)	Nutrition – Primary Care Intranet (hscni.net) Infant Nutrition | NI Formulary (hscni.net)
	Adult oral nutritional supplements	• Assess nutritional risk and use "food first" approach before prescribing oral nutritional supplements • If prescribing, use NI formulary choices. Powdered ONS is first line and more than **50% cheaper** than ready-made ONS and is the cost-effective option in primary care. Set goals for treatment. See ready reckoner for primary care • Review regularly and assess for continued need • Do not initiate products that should be dietetic led unless after specific recommendation from a dietitian • Palliative care – refer to guidance • People at risk of harm due to substance use -refer to guidance	Nutrition – Primary Care Intranet (hscni.net) 9.4.1 Step 1-Identification of nutritional risk 9.4.6-Step 6-Review need for ONS 9.4.7 Step 7-When to Discontinue ONS 9.4.5.2-Dietitian Led Products Oral nutrition support - resources for patients, carers and healthcare professionals
	Vitamins	Do not prescribe vitamins and minerals unless in line with an ACBS approved indication i.e. only in the management of actual or potential vitamin or mineral deficiency; they are not to be prescribed as dietary supplements or as a general 'pick-me-up' • **Vitamin B compound** preparations are considered by the Joint Formulary Committee to be less suitable for prescribing.	Nutrition – Primary Care Intranet (hscni.net) https://primarycare.hscni.net/download/DocLibrary/Pharmacy/Clinical/Nutrition/vitamins/Prescqip-Vitamines-and-Minerals.pdf

		• **Do not initiate** vitamin B compound or vitamin B compound strong tablets for any of the following indications: » Prevention of WE in alcoholism » Dietary supplementation » Prevention of deficiency » Maintenance treatment following treatment of deficiency • If justified, **Vitamin B compound strong** should be prescribed rather than vitamin B compound as it represents better value for money	
Musculoskeletal & joint diseases	Drugs used in rheumatic disease	• Do not prescribe Naproxen EC – plain Naproxen is preferred • Do not prescribe mefenamic acid due to its low therapeutic window which increases the risk of accidental overdose • Use cost-effective NSAID gels e.g. ibuprofen 5% gel • Do not prescribe rubefacients e.g. Movelat gel/cream • Discontinue Penicillinamine after 1 year if not effective. (Note: it is not appropriate to prescribe DMARDs to care home patients with dementia)	10.3.2 Rubefacients, topical NSAIDs, capsaicin, and poultices | NI Formulary (hscni.net) Pain – Primary Care Intranet (hscni.net) (NSAID and Cox II review tool) Penicillamine SCG

	Methocarbamol	Do not routinely prescribe methocarbamol • Prescribing is not supported due to limited clinical value. It is classified by the BNF as 'less suitable for prescribing'. • Review existing patients and stop if no benefit. • .	Prescribing Limited Evidence Stop List | NI Formulary (hscni.net) Patient information – Changes to methocarbamol prescribing | NI Formulary (hscni.net)

	Drugs used for Gout	• Review patients being treated for gout. Consider: • Has patient been symptom free for many years? • Has the patient addressed modifiable risk factors/stopped diuretics? • Has renal function improved? • Does the patient now have normal uric acid levels? • MHRA Alert - Febuxostat: Updated Advice For The Treatment Of Patients With A History Of Major Cardiovascular Disease	Useful deprescribing resource flow chart on Presqipp – https://www.prescqipp.info/media/4967/attachment-1-allopurinol-algorithm-20.pdf See details of MHRA alert here

	Quinine	• Quinine is very toxic in overdose. It is not recommended for treating idiopathic leg cramps due to poor benefit-to-risk ratio
		• Consider only when:
		  • cramps are very painful or frequent
		  • other treatable causes of cramp have been ruled out
		  • non-pharmacological measures have been ineffective
		• Stop if no benefit after four weeks. If prescribing continues, re-assess every 3 months. Where there is long-term use consider a trial discontinuation
		•
			Pain – Primary Care Intranet (hscni.net)
			Quinine Review Tool
			
			10.2.3 Nocturnal Leg Cramps | NI Formulary (hscni.net)

Skin	Bath and shower emollients ***NEW***	• Do not prescribe Bath and shower emollient preparations Suitable emollients may be prescribed as soap substitutes instead.	B244: Bath and shower emollient preparations The NI Formulary (Chapter 13 – Skin) B228: Emollients, paraffin content and fire risk B239: Emollients B307: Cost effective prescribing in dermatology
Wound Care	Silicone Products Silicone scar treatment preparations	• Do not prescribe silicone scar treatment preparations for routine cosmetic treatment. • Advise patients to purchase appropriate treatments.	Bulletin 161: Wound care - Silicone scar treatment | PrescQIPP C.I.C

	Examples: Cica-care, Dermatix Clear, Kelo-cote gel, Mepiform silicone gel, Scar Fx, Silderm.		
Cardiovascular	Naftidrofuryl 100mg capsules	Currently there is insufficient evidence to recommend the routine use of peripheral vasodilators. Patients commenced by exception must be assessed for improvement after 3–6 months and stopped if no symptomatic benefit	Naftidrofuryl oxalate | Prescribing information | Peripheral arterial disease | CKS | NICE
	Nebivolol 5mg tablets cost-effective-choices	Due to the high cost of all other strengths, nebivolol 5mg should be the first-choice for doses 2.5mg-10mg Due to the *very high* cost of nebivolol 1.25mg tablets then 2.5mg tablets should be prescribed with half a tablet dosing NB: 1.25mg is the heart failure titration dose only	Cost Effective Choices | NI Formulary (hscni.net)
	Propranolol use in Generalised Anxiety Disorder (GAD)	NICE guidance on generalised anxiety disorder and social anxiety disorder does not recommend propranolol for this indication. The SPPG has moved propranolol for the treatment of anxiety onto the Limited Evidence List	Prescribing Stop List | NI Formulary (hscni.net)

	Propranolol 80mg MR capsules	The cost of Propranolol 80mg m/r is significantly more than the immediate release tablets. To meet daily dose requirements, where appropriate, prescribers are asked to consider prescribing immediate release tablets and not the modified release capsules (bearing in mind the tablet burden for individual patients) This may be of use particularly when considering step-down of dose following patient reviews	4.7.4.2 Migraine prophylaxis | NI Formulary (hscni.net) Potential under-recognised risk of harm from the use of propranolol — HSIB
	Atorvastatin 30mg & 60mg	Do not prescribe atorvastatin 30mg and 60mg tablets. They are significantly more expensive than the other strengths of atorvastatin tablets.	2.12 Lipid-regulating drugs | NI Formulary (hscni.net)
	Omega-3-acid ethyl esters (Omacor/ Maxepa)	This is not recommended for use within NI. Do not prescribe.	Prescribing Stop List | NI Formulary (hscni.net)