Herts and West Essex ICB Guide to Deprescribing Immediate-Release (IR) Fentanyl in Primary Care

IR Fentanyl initiated by a palliative care specialist as third line breakthrough pain option when morphine and oxycodone are either contraindicated or inappropriate? [1]

YES

REVIEW

- Review the continued need for IR fentanyl at each appointment.
- IR fentanyl preparations should be discontinued immediately if the patient no longer experiences breakthrough pain episodes. There should be no noticeable effects on cessation of treatment, but possible symptoms of withdrawal are anxiety, tremor, sweating, paleness, nausea and vomiting.[2]
- If IR fentanyl is continued, see below for factors to consider during review process.

NO

HWE ICB non-formulary indication: **Review and consider stopping**

- **See Appendix 1 below to aid the review.**
- Review patients who are currently being prescribed IR fentanyl for a non-palliative indication to establish whether prescribing is safe and appropriate.
- IR fentanyl buccal tablets, lozenges and sprays are **not** recommended for prescribing in primary or secondary care.[5]

Additional considerations if IR fentanyl is continued:

- Prescribe IR fentanyl preparations by **brand.** The brands are not interchangeable and therefore prescribing by brand reduces the risk of prescribing and dispensing errors.[2]
- Check patient is taking IR fentanyl as prescribed.
- Monitor usage and quantities prescribed to check for over-ordering.
- Be vigilant for signs of drug misuse by the patient, family or carers (fentanyl has a high street value).
- If a patient is regularly using more than four doses of IR fentanyl a day, the pain / palliative care specialist should be alerted so that they can review the background opioid to an optimal dose.[3]
- Patients receiving IR fentanyl who are still experiencing breakthrough pain and have not had IR morphine first-line should be considered for a switch (with support from the specialist).[2]

APPENDIX 1

Deprescribing Review:

Use PrescQIPP: Bulletin 285: Fentanyl which provides support to clinicians when deprescribing opioids.

1. Assess risk of dependence.
2. If a specialist initiated IR fentanyl, consider liaising with them and set up an initial meeting (and then follow up meetings) to discuss the need to deprescribe IR fentanyl.
3. Reassess the type of pain the patient has if unknown.
4. If pain remains inadequately controlled despite optimising treatment, consider seeking specialist advice.
5. Invite the patient in for a review to discuss need for deprescribing IR fentanyl. Consider sending the Fentanyl Immediate-Release Patient Information Leaflet[6] in advance of the appointment which provides a rational for deprescribing.
6. Explain the need for deprescribing IR fentanyl and agree on a reduction plan in partnership with the patient and consider use of patient opioid treatment plan agreement[7] and a pain diary if appropriate.
7. Agree on a gradual reduction plan with the patient.
8. Usual guidance when weaning opioids is to reduce the dose by approximately 10% weekly or two weekly tailored to the patient. Reducing IR Fentanyl products depends on the strength and dose taken and strength of the product that is available which may require individualisation according to the patient. Patient collaboration and engagement is key to successful tapering.[4]
9. If patients experience difficulties with a dose reduction, encourage them to persevere and suggest delaying the next step down by one week or longer and discuss importance of using non-drug related pain management strategies. Do not revert to a higher dosage.[4]
10. Do not increase or add alternative medicines such as pregabalin, gabapentin, or dihydrocodeine.[4]
11. Consider arranging weekly prescriptions.
12. Ensure a regular review every two to four weeks (or sooner) with the patient, depending on the reduction schedule.
13. Consider allocating one or two named clinicians to support the patient with the regular reviews and signing prescriptions as well as an MDT approach for complex prescribing decisions.
14. Consider appropriate non-medication treatments e.g. referral to a social prescriber, talking therapies, musculoskeletal services (MSK) or pain management workshops.[4]

Supporting information

- IR fentanyl is included in the NHS England Items which should not routinely be prescribed in primary care policy guidance which recommends that IR fentanyl is an item which is clinically effective, but there are more cost-effective products available. The recommendations do not apply to patients undergoing palliative care treatment and where the recommendation to use IR fentanyl, has been made by a multidisciplinary team and/or other healthcare professional with a recognised specialism in palliative care. This is in line with NICE CG140 Palliative care for adults: strong opioids for pain relief. [8,9]
- **IR fentanyl products are licensed only for the treatment of breakthrough pain in adults receiving maintenance opioid therapy for chronic cancer pain. They are not licensed for any other type of pain.** [3]
- For unlicensed indications IR fentanyl should not be prescribed in primary care.
- In line with NICE CG140, patients should be offered oral IR morphine for first-line rescue medication for breakthrough pain in patients on maintenance oral morphine treatment. [9]
- NICE CG140 recommends not to offer IR fentanyl as first-line rescue medication for breakthrough pain and if pain remains inadequately controlled despite optimising treatment, consider seeking specialist advice. [9]
- In Hertfordshire and West Essex IR fentanyl is not recommended for prescribing in primary or secondary care except for when patients are undergoing palliative care treatment. [1,5]
- PresQIPP Bulletin 285 Fentanyl supports the review of the prescribing of IR fentanyl in line with national guidance. [2]
- Switching from one opioid to another should only be recommended or supervised by a healthcare practitioner with adequate competence and sufficient experience. If uncertain, ask for advice from a more experienced practitioner. [2]
- Fentanyl IR Patient Information Leaflet provides information for clinicians to provide to patients regarding prescribing of IR fentanyl. [6]

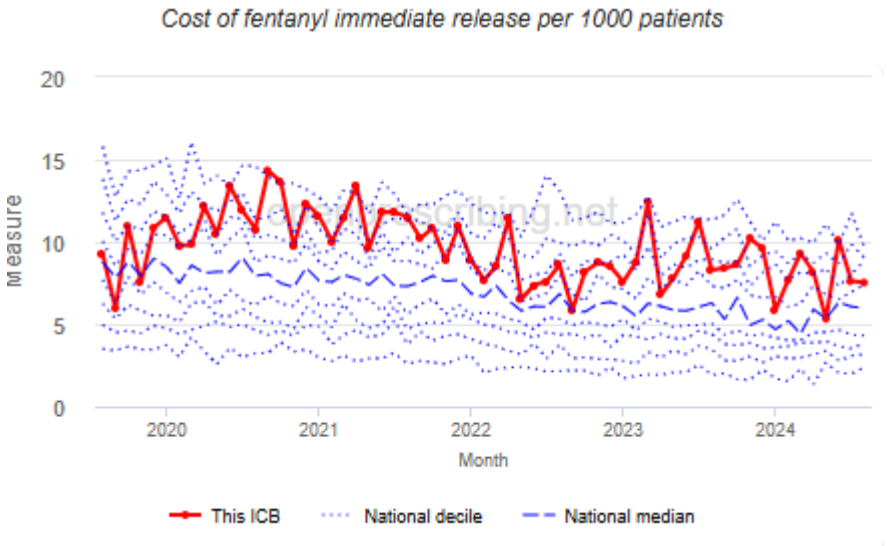
IR Fentanyl Usage & Financial Impact in Herts and West Essex

In August 2024 HWE ICB spent £12,488 on IR fentanyl.

In the last 6 months if the ICB had prescribed in line with the national median, we would have saved the system £23,195.

In the last 6 months, if the ICB had prescribed in line with the ICBs prescribing the least IR fentanyl preparations, we would have saved the system £58,499. [10]

Open prescribing data from August 2024 [10]



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Developed By:	Ashik Shah, Pharmaceutical Advisor, Hertfordshire and West Essex Integrated Care Board
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