THE UNIVERSITY OF WESTERN AUSTRALIA

WESTERN AUSTRALIAN CENTRE FOR HEALTH AGEING

CENTRE FOR OPTIMISATION OF MEDICINES

POLYPHARMACY / MULTIPLE DRUG CLASSES

Deprescribing in older people: A clinical practice guideline

dRx™

Type	Recommendation

WHEN TO DEPRESCRIBE

CBR Given the potential clinical and economic benefits in reducing inappropriate polypharmacy, we suggest that in addition to applying a targeted approach to deprescribe specific drug classes, regular medication review is offered to older people taking multiple long-term medicines. We suggest deprescribing medicines that meet one of the categories below:

- With no clear indication, an obvious contraindication, or if there is an inappropriate prescribing cascade;
- With adverse effects or interactions that outweigh the potential benefits;
- Used for symptomatic relief, where the symptoms are resolved and unlikely to recur; or
- Used for prevention, when the potential benefits are uncertain or unlikely to be realised.

GPS Deprescribing decisions should be made in consultation with the person and their GP and/or specialist providers to ensure it aligns with their preferences, goals and overall treatment plans (ungraded good practice statement).

GPS In the context of multimorbidity and polypharmacy, healthcare providers should refer to existing high-quality disease-specific guidelines relevant to the condition to identify medicines that may be suitable for deprescribing (ungraded good practice statement).

GPS Deprescribing should be a preference-sensitive decision, requiring a shared decision-making approach (ungraded good practice statement).

ONGOING TREATMENT

CBR We suggest continuing medicines after confirming that the pharmacotherapy is clearly indicated, the benefits of the medicine are expected to outweigh the potential harms and that this aligns with the individual's goals and preferences.

In the context of multimorbidity and polypharmacy, deprescribing one medicine may necessitate a change in other pharmacotherapies due to a potential increase or reduction in risks (e.g. drug-drug or drug-disease interactions). There may be a need for a "deprescribing cascade" or prescribing of another more suitable medicine to optimise therapy.

HOW TO DEPRESCRIBE

CBR **Methods**

When a medicine is identified as being suitable for deprescribing, we suggest developing an individualised deprescribing plan in collaboration with the person and/or their carers/family members, by referring to the specific guidance in individual drug sections in this guideline. **Broadly,** for medicines where adverse drug withdrawal events (ADWEs) or disease recurrence are likely, we suggest tapering the dose rather than abrupt cessation. For tapering,* we suggest halving the dose at two to four weeks intervals, until half of the lowest standard dose formulation is reached, then ceasing the medicine completely. However, smaller dose reductions may be appropriate (e.g. high baseline dose or high risk of symptom recurrence).

We suggest switching from regular doses to pro re nata doses be considered if appropriate (e.g. antipsychotics). For medicines with longer half-lives, we suggest tapering may not be required.

We suggest deprescribing one medicine at a time. However, up to three medicines may be deprescribed simultaneously if unlikely to cause ADWEs and practical, or if withdrawal effects can be clearly attributed to an individual medicine.

If deprescribing cannot be fully implemented and/or maintained, we suggest the following options be considered and offered to the individual as appropriate:

- Continue with a tapered dose and delay further dose reductions by an agreed interval for stabilisation;
- Continue with the tapered dose but forego further dose reductions;
- Restart the target medicine(s) at approximately 75% of the previously tolerated dose; or
- Restart the target medicine(s) at the original dose.

** When deprescribing fixed-dose combinations, if tapering of one active component is required, consider prescribing separate (i.e. free-dose) combination products.*

CBR **Sequence of deprescribing target medicine**

Once the medicines for deprescribing are agreed upon, we suggest the order of deprescribing be decided collaboratively between the individual and their prescriber.

We suggest considering the priorities of the person, including their preference and impact on well-being, alongside the characteristics of the medicines, taking into account the balance of potential:

- Risk of harm from continued use;
- Benefit from continued use;
- Adverse drug withdrawal events if the medicine is stopped; and
- Cost burden

See Figure 1. Prioritisation matrix for deprescribing.

CBR, consensus-based recommendation; GPS, good practice statement

GPS With informed consent from the individual or their supported decision-maker, prescribers should provide written prescribing and deprescribing plans to relevant healthcare providers involved in the person's care (ungraded good practice statement).

GPS Prescribers should document informed consent, the rationale for prescribing or deprescribing, and, if applicable, the dose tapering schedule, order of withdrawal, and monitoring plan (ungraded good practice statement).

MONITORING

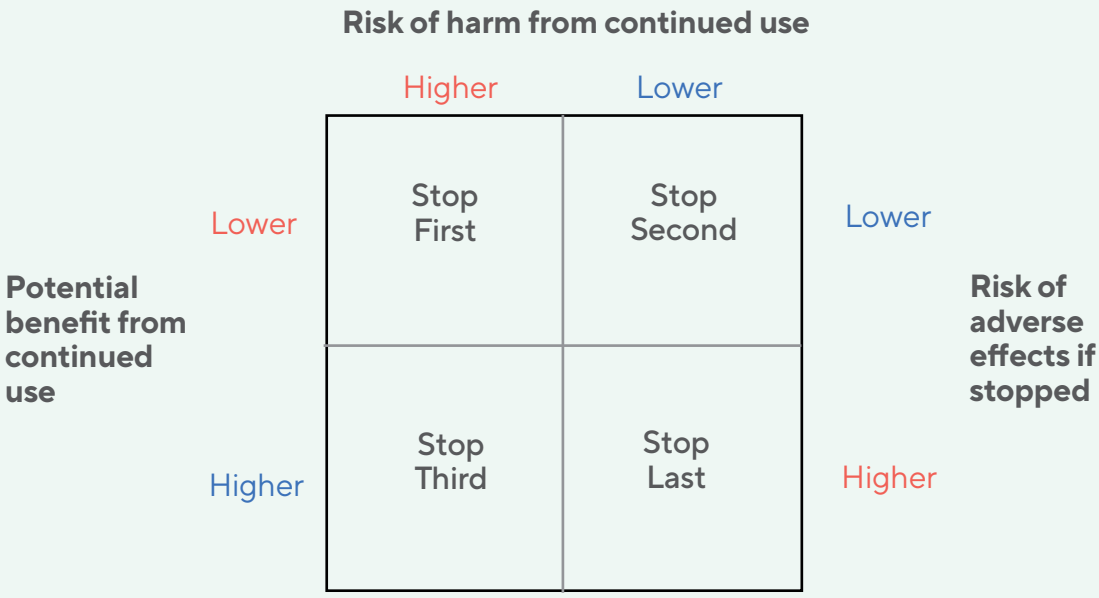
CBR In general, we suggest closely monitoring for ADWEs and any health-related outcomes (e.g. physical/psychological changes) every two weeks following each dose adjustment until at least four weeks after the medicine is fully discontinued. After this initial period, we suggest monthly monitoring for at least three months, followed by monitoring every six months thereafter. If in-person visits are not practical, we suggest informing people to report symptom recurrence and/or any appearance of new symptoms during monitoring and setting parameters for people for which point to initiate contact.

We suggest individualising monitoring intervals (more or less frequent) in partnership with the person and their carers based on practicality, individual preferences, responses and tolerance. For instance, deprescribing multivitamins taken without a current indication in a robust person may require less frequent monitoring than other drug classes such as an antihypertensive or an antipsychotic. For specific guidance, we suggest referring to the individual drug sections in the guideline.

Additionally, we suggest monitoring should occur at any time there is a change in the individual's risk-benefit profile (e.g. if the person becomes unwell or there is a change in their clinical status or preferences).

CBR, consensus-based recommendation; GPS, good practice statement

Figure 1. Prioritisation matrix for deprescribing



Consider the individual's priorities, including their preferences and the impact on their well-being, alongside the characteristics and cost of the medicines

Note:

Evidence is drawn from studies involving participants aged ≥ 65 years and over.

Chronological age may not reflect health status. Among Aboriginal and Torres Strait Islander peoples, individuals aged 50 years and over are considered older.

Statements in this guideline are not prescriptive and should be applied using a shared decision-making approach.

Access to healthcare services may vary and can influence healthcare decisions.

Medicine needs may change over time; medicines may be restarted if clinically necessary, based on shared decision-making and informed consent.

For supporting evidence and further information, please visit **deprescribing.com** or scan the QR code:

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