THE UNIVERSITY OF WESTERN AUSTRALIA

WESTERN AUSTRALIAN CENTRE FOR HEALTH AGEING

CENTRE FOR OPTIMISATION OF MEDICINES

LEVODOPA

Deprescribing in older people: A clinical practice guideline

dRx™

LEVODOPA

Levodopa with benserazide or carbidopa*

Levodopa with carbidopa and entacapone

*Common Pharmaceutical Benefits Scheme medicines

Type	Recommendation
	WHEN TO DEPRESCRIBE
CBR	We suggest deprescribing be offered to older people taking levodopa when: • There has been no clinically meaningful improvement in motor symptoms or functional outcomes after at least three months of uninterrupted therapy at an optimal dose; or • Non-motor side effects are intolerable; or • The overall adverse impact of non-motor side effects outweighs the treatment benefits.
GPS	Deprescribing decisions should be made in consultation with the individual, their carer/family members, GP and/or specialist provider to ensure it aligns with their preferences, goals and overall treatment plans (ungraded good practice statement).
	ONGOING TREATMENT
CBR	We suggest continuing levodopa if the benefits (e.g. motor or non-motor) clearly outweigh the potential risks (e.g. fall risk, orthostatic hypotension and sedation); however, we suggest reassessing the need for long-term therapy periodically and monitoring for emerging risks and benefits.
	HOW TO DEPRESCRIBE
CBR	We suggest levodopa may be ceased abruptly (e.g. when there is a need to rapidly assess levodopa responsiveness or in the presence of significant toxicity) or gradually tapered by reducing the dose by one tablet or 100 mg every two weeks until it is fully withdrawn (e.g. for people on high baseline daily doses), ensuring individuals remain symptom-free before initiating each tapering.
	MONITORING
CBR	We suggest closely monitoring for worsening motor (e.g. tremors, bradykinesia, rigidity) and non-motor symptoms (e.g. mood changes, cognitive decline) such as every one to two weeks.

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

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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