Table 1. Summary recommendation table for deprescribing polypharmacy or multiple drug classes

Type	Recommendation/Statement
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 • 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).
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.
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:

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	• Continue with a tapered dose and delay further dose reductions by an agreed interval for stabilisation; or • Continue with the tapered dose but forego further dose reductions; or • 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 medicines** 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 **Prioritisation matrix for deprescribing** **Risk of harm from continued use** Higher Lower **Potential benefit from continued use** Lower: Stop First Higher: Stop Last Lower Higher **Risk of adverse effects if stopped** Footnote: Consider the individual's priorities, including their preferences and the impact on their well-being, alongside the characteristics and cost of the medicines
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).

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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).
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; GP, general practitioner

Consensus-based recommendations (CBRs) are developed following a systematic review when the certainty of evidence, assessed using the GRADE approach, is low or very low. Good practice statements (GPS) are not derived directly from a systematic review but are formulated to support recommendations or guide deprescribing when indirect yet high-quality evidence exists and GPS criteria are met.

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Table 2. Summary recommendation table for deprescribing individual medicines, alphabetically ordered

Topic	Type	Recommendation/Statement
Analgesics	CBR	We suggest deprescribing be offered to older people taking opioid or non-opioid analgesics with: • No ongoing indication or benefits (e.g. long-term opioid for chronic non-cancer pain with little benefit in pain relief or improving function, pain related to an acute injury that has healed, or chronic pain that is controlled with non-pharmacological measures); or • Adverse effects or interactions outweigh the potential benefits (e.g. presence of obvious contraindication such as recurrent falls, significant drug-drug interactions, cognitive impairment, sedation, respiratory depression, falls, osteoporosis, constipation, and immunosuppression)
	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).
	CBR	If deprescribing is unsuccessful despite multiple attempts, we suggest maintaining the lowest effective dose; however, we suggest reassessing the need for long-term therapy at least annually. We suggest appropriate non-pharmacological therapies and/or safer alternatives be considered and offered.
	GPS	For older people using opioid analgesics to manage cancer-related pain in the palliative stage, healthcare providers should consider seeking input from palliative care providers (ungraded good practice statement).
	CBR	**Non-opioids (excluding paracetamol)** We suggest individualising the tapering schedule and adjusting it according to the individual's response to establish the lowest effective dose if therapy continuation becomes necessary. In general, we suggest reducing the non-opioid analgesic dose gradually every 2-4 weeks. **Non-opioid (paracetamol)** We suggest tapering may not be needed for paracetamol. However, tapering may be required to establish the lowest effective dose if therapy continuation becomes necessary.
	GPS	**Opioids (ungraded good practice statements)** For people taking opioids for < 12 months, healthcare providers should consider gradually reducing by 5-10% of the morphine equivalent dose or 10-25% of the opioid dose every week. If symptoms recur, return to the previously tolerated dose until symptoms resolve and plan for a more gradual taper For people taking opioids for 12 months or more, healthcare providers should consider gradually reducing by 5-10% of the morphine equivalent dose or 10-25% of the opioid dose every month. If symptoms recur, return to the previously tolerated dose until symptoms resolve and plan for a more gradual taper. Healthcare providers should consider advising people of the increased susceptibility to opioid overdose or opioid poisoning during

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		dose tapering due to a change in opioid tolerance, and that extra caution is required, especially if returning to doses prior to deprescribing.
	GPS	Healthcare providers should consider offering non-pharmacological interventions (e.g. pain management services, walking programs), referrals to relevant allied health professionals, and psychological support as part of the management plan as appropriate. If pharmacological treatment is clinically indicated, a stepwise approach to pain management should be adopted with consideration given to on-demand or intermittent dosing of simple analgesics when appropriate (ungraded good practice statement).
	CBR	We suggest closely monitoring for pain, functional status, and quality of life every two weeks until at least four weeks after the medicine is fully ceased if practical. After this initial period, we suggest monthly monitoring for at least three months, followed by monitoring every six months thereafter to maintain therapeutic relationships with the individuals. This should be tailored based on individual factors such as their preferences, responses and tolerance to deprescribing. If in-person visits are impractical, we suggest advising people to report symptoms as needed.
	GPS	Healthcare providers should use validated assessment tools to evaluate changes in pain severity, functional status, and quality of life (ungraded good practice statement).
Anticholinergics	CBR	We suggest deprescribing of genitourinary anticholinergics be offered to older people: 1. With cognitive impairment, delirium, dementia and/or a high risk of falls due to the risk of adverse cognitive outcomes and sedation potentially outweigh the benefits of continued use, especially in patients with high anticholinergic burden; or 2. With no clear indication (e.g. indications in line with current treatment guidelines) or no identifiable benefit; or 3. For drug-induced symptoms where the original drug can be suitably reduced, discontinued, or replaced by another drug (e.g. inappropriate prescribing cascade).
	GPS	Deprescribing decisions should be made in consultation with the person and their specialist providers to ensure it aligns with their preferences, goals and overall treatment plans (ungraded good practice statement).
	CBR	If multiple attempts at deprescribing are unsuccessful and non-pharmacological interventions or alternative medications with fewer anticholinergic effects are not effective/possible, we suggest continuing the genitourinary anticholinergic at the lowest effective dose; however, the need for long-term therapy should be reassessed periodically.
	CBR	Generally, we suggest discontinuing genitourinary anticholinergics without the need for tapering. Tapering may be considered for high-dose therapy, and some individuals may prefer gradual tapering by reducing the dose or dosing frequency per week that the medicine is taken.
	GPS	Healthcare providers should consider offering adequate education on lifestyle interventions (e.g. bladder training, pelvic floor exercises, timed toileting) to individuals, as appropriate, in addition to referrals to a continence advisor (ungraded good practice statement).
	CBR	We suggest periodic evaluation of individual preferences, and psychological effects of deprescribing, and advising individuals to report to their healthcare professionals any symptoms of recurrence or disease exacerbation (e.g. any return or worsening of urgency, frequency, incontinence, or nocturia).

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Anti-dementia medicines	CBR	We suggest deprescribing be offered to older people taking cholinesterase inhibitors for the cognitive symptoms of dementia: • For dementias other than Alzheimer's disease, dementia of Parkinson's disease, Lewy body dementia, or vascular dementia, due to limited evidence for efficacy; • For Alzheimer's disease, mixed dementia, dementia of Parkinson's disease, Lewy body dementia, or vascular dementia, if treatment has continued for more than 12 months without clear benefit or if dementia has progressed to a severe/end-stage ; or • In the presence of significant side effects that impact their quality of life.
	GPS	Deprescribing decisions should be made in consultation with the individual, their carer/family members, specialist provider to ensure it aligns with their preferences, goals and overall treatment plans (ungraded good practice statement).
	CBR	If deprescribing is unsuccessful despite multiple attempts, we suggest maintaining the lowest effective dose; however, we suggest reassessing the need for long-term therapy periodically.
	CBR	We suggest individualising the tapering schedule and adjusting it according to the individual's response. In general, we suggest halving the daily dose every four weeks, ensuring the absence of withdrawal symptoms or worsening of global, cognitive, functional, or neuropsychiatric outcomes before initiating further tapering. Once half the lowest standard dose formulation is reached, we suggest ceasing completely.
	CBR	For people on combination therapy of cholinesterase inhibitors and medicines with anticholinergic properties, we suggest first considering the deprescribing of anticholinergics due to the potential adverse effects on cognitive function. Tapering of anticholinergics can generally follow the same approach as cholinesterase inhibitors tapering; however, we suggest individualising the tapering schedule and adjusting it as needed according to the individual's response. The dose for concomitant cholinesterase inhibitors may also need to be adjusted due to the reduction in opposing mechanisms of action following the dose reduction of anticholinergics.
	GPS	Healthcare providers should consider and offer adequate non-pharmacological management options to individuals and their families, care providers(e.g. verbal de-escalation, psychological intervention, engaging individuals in meaningful activities, increased staff-to-patient ratio, increased staff training in behaviour management) as appropriate to manage challenging behaviours in dementia (ungraded good practice statement).
	CBR	We suggest closely monitoring individuals for withdrawal symptoms or symptoms of disease exacerbation (e.g. worsening neuropsychiatric symptoms including agitation and apathy, cognitive decline, worsening behavioural symptoms, reduced ability in activities of daily living) every one to two weeks following each dose adjustment until at least four weeks after the medicine is fully ceased if practical. After this initial period, we suggest monthly monitoring for at least three months, followed by monitoring every six months thereafter. However, this should be tailored based on individual factors such as their preferences, responses and tolerance to deprescribing. If in-person visits are impractical, we suggest advising people to report symptoms and/or any appearance of new symptoms as needed.
	GPS	Healthcare providers should provide clear guidance to care providers on recognising withdrawal symptoms and symptoms of disease exacerbation, enabling them to seek timely medical advice (ungraded good practice statement).

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	GPS	Healthcare providers should use validated assessment tools to evaluate changes in cognitive function, neuropsychiatric symptoms, functional status, and quality of life (e.g. Psychogeriatric Assessment Scales for cognitive function, Neuropsychiatric Inventory for neuropsychiatric symptoms, Functional Status Questionnaire for functional status, and EQ-5D for health-related quality of life) (ungraded good practice statement).
Antidepressants	CBR	We suggest deprescribing be offered to older people taking antidepressants for major depressive disorder: 1. Who have achieved symptomatic remission or clinical stability for 6 to 12 months with uninterrupted treatment after appropriate assessment; or 2. When the indication for continued use is unclear or unknown (e.g. no benefit has been derived).
	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).
	CBR	If deprescribing is unsuccessful despite multiple attempts, taking into account the possibility of withdrawal effects rather than recurrence of symptoms, we suggest maintaining the lowest effective dose; however, we suggest reassessing the need for long-term therapy periodically.
	CBR	We suggest individualising the tapering schedule and adjusting it according to the individual's response. In general, we suggest reducing the dose by 25% every one to four weeks (taking into consideration the half-life of the antidepressant), ensuring the absence of physical or neuropsychiatric withdrawal symptoms before initiating further tapering. Once half the lowest standard dose formulation is reached for another one to four weeks, we suggest ceasing completely if no sign of reoccurrence of symptoms. However, smaller dose reductions may be appropriate or preferred by some individuals, particularly as lower doses are approached. In particular, for people at increased risk of withdrawal effects, such as those with prolonged use prior to withdrawal, high-dose regimens, or a prior history of withdrawal difficulties, slower individualised tapering strategies may be appropriate. This may include dose reductions of 5-10% at intervals of four weeks or longer, and consideration of doses below half the lowest commercially available strength.
	GPS	Healthcare providers should consider and offer adequate non-pharmacological management options (e.g. psychological interventions for psychiatric disorders such as cognitive-behavioural therapy) to individuals and their families or carers as appropriate (ungraded good practice statement).
	CBR	We suggest closely monitoring for worsening neuropsychiatric symptoms (e.g. increased anxiety, agitation, depressive symptoms) and cognition which could be short-lived or protracted, severe or mild, in addition to monitoring changes in psychological or physical health status, and quality of life every one to two weeks following each dose adjustment until at least four weeks after the medicine is fully ceased if practical (recognising the possibility of withdrawal effects rather than recurrence of symptoms). After this initial period, we suggest monthly monitoring for at least three months, followed by monitoring every six months thereafter. However, this should be tailored based on individual factors such as their preferences, responses and tolerance to deprescribing. If in-person visits are impractical, we suggest advising people to report symptoms as needed.

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Antiepileptics	CBR	**Epilepsy indication** We suggest deprescribing can be considered if preferred by the individual, provided they have been seizure-free for at least two years, and the risks (e.g. seizure recurrence implications such as driving license implications) and benefits (e.g. reduced adverse effects, interactions or treatment burden) are clearly communicated following an individualised risk assessment, and individual values, preferences, and goals are considered.
	CBR	**Non-epilepsy indications** We suggest deprescribing be offered to older people taking antiepileptics for non-epilepsy indications (e.g. neuropathic pain or behavioural and psychological symptoms of dementia) when there is no evidence of therapeutic benefit after a reasonable trial at an optimal dose (e.g. ≥ two to three months) or when the treatment is poorly tolerated.
	GPS	**Epilepsy and non-epilepsy indication** Deprescribing decisions should be made in consultation with the individual and their neurologist to ensure alignment with the individual's preferences, goals, and overall treatment plan (ungraded good practice statement).
	CBR	**Epilepsy indication** We suggest continuing antiepileptics for the indication of epilepsy for a minimum of two years without a seizure, or longer (as every additional year of seizure freedom reduces the risk of seizure recurrence), balanced by the individualised risk-benefit assessment.
	CBR	**Non-epilepsy indication** We suggest continuing antiepileptics for non-epileptic indications (e.g. primidone for essential tremor) when the benefit clearly outweighs the risk.
	CBR	For all indications, we suggest individualising the tapering schedule and adjusting it according to the individual's response.
	CBR	**Epilepsy indication** For epilepsy, we suggest reducing the dose of antiepileptics by 10-25% monthly, with close monitoring for breakthrough seizures. If seizure activity occurs, we suggest returning to the previous effective dose. However, we suggest the speed of tapering be guided by the person by taking into considerations other factors such as driving implications.
	CBR	**Non-epilepsy indications** In general, we suggest reducing the dose gradually by 25% of the previous dose every week initially. If there is any indication of symptom recurrence (e.g. anxiety, restlessness, pain) or if used for longer than a month consider tapering more gradually (up to 6 months may be preferred for a barbiturate or clonazepam).
	CBR	**Epilepsy and non-epilepsy indication** We suggest closely monitoring for symptom recurrence (e.g. seizure recurrence or changes in psychological symptoms for non-epilepsy indications) and whether other concurrent medicines require adjustments due to changes in drug-drug interactions when tapering antiepileptics. Monitoring should ideally occur every one to two weeks following each dose adjustment until at least four weeks after the medicine is fully ceased if practical. After this initial period, we suggest monthly monitoring for at least three months, followed by monitoring every six months thereafter. However, this should be tailored based on individual factors such as their preferences, responses and tolerance to deprescribing.

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		If in-person visits are impractical, we suggest advising people to report symptoms and/or any appearance of new symptoms as needed.
	GPS	**Epilepsy indication** For individuals with epilepsy, healthcare providers should ensure a seizure action plan is in place in case breakthrough seizures occur and encourage individuals to track any seizure activities (ungraded good practice statement).
Antiglaucoma preparations	CBR	We suggest deprescribing be offered to older people who are taking anti-glaucoma preparations where the extent of glaucoma progression after treatment discontinuation is unlikely to impact the quality of life in their lifetime. Deprescribing decisions should be made in consultation with the patient and their prescriber (ophthalmologist or optometrist) to ensure it aligns with their preferences, goals and overall treatment plans.
	GPS	Deprescribing decisions should be made in consultation with the person and their treating ophthalmologist and/or optometrist to ensure it aligns with their preferences, goals and overall treatment plans (ungraded good practice statement).
	CBR	We suggest ceasing anti-glaucoma preparations without the need for tapering.
	CBR	We suggest closely monitoring for signs of glaucoma progression and intraocular pressure for two to eight weeks after discontinuing the medicine, then 3 to 6 monthly in the first year. Thereafter can be extended to 6-12 monthly based on the severity of glaucoma and patient preferences. We suggest advising patients to inform their healthcare providers of any concerning symptoms in between appointments.
Anti-gout preparations	CBR	We suggest deprescribing be offered to older people taking long-term **urate-lowering therapy** who have been in clinical remission for at least a year, with a normal serum uric acid concentration (< 0.36 mmol/L for non-tophaceous gout, or < 6 mg/dL), no tophi, no flares, when the risks of adverse drug events, drug-drug interactions, and treatment burden outweigh the benefits of preventing gout reoccurrence.
	CBR	We suggest deprescribing be offered to older people taking long-term **colchicine** for prophylaxis of gout flares, except when initiating urate-lowering treatment for a short period of time (typically six months or more until no further attacks and the target serum uric acid concentration has been achieved).
	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).
	CBR	We suggest continuing long-term urate-lowering therapy with tophi.
	CBR	We suggest continuing long-term anti-gout preparations for evidence-based indications other than gout (e.g. colchicine used for pericarditis) for the appropriate duration of use, as the benefits of continued use likely outweigh the risks, under specialist care.
	CBR	In general, we suggest halving the daily dose every two weeks, ensuring individuals remain symptom-free before initiating each tapering. Once half the lowest standard dose formulation is reached, we suggest ceasing completely.
	CBR	We suggest closely monitoring for serum uric acid concentrations, renal function, and gout flares every two weeks for at least a month following deprescribing if practical. After this initial period, we suggest monthly monitoring for at least three months, followed by monitoring every six months thereafter. However, this should be tailored based on individual factors such as their preferences, responses and tolerance to deprescribing.

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		If in-person visits are impractical, we suggest advising people to report symptom recurrence as needed. We suggest providing education on how to manage an acute gout attack.
	CBR	We suggest the periodic assessment of cardiovascular risks and the appropriate management of comorbidities in people with gout and/or hyperuricaemia, including offering lifestyle modification advice where appropriate to modify cardiovascular risk factors.
Antihypertensives	CBR	Following shared decision-making, we suggest deprescribing of antihypertensives be offered to older people with: 1. Relative contraindications such as: • Verapamil or diltiazem used in heart failure with reduced ejection fraction in the absence of atrial fibrillation (AF); • Beta-blockers or verapamil/diltiazem use in inappropriate bradycardia (e.g. < 60 beats/minute) or any evidence of atrioventricular block causing symptoms (e.g. exertion fatigue); • Loop/thiazide diuretics used in symptomatic hyponatremia, diabetes mellitus, or gout; • Refractory/persistent hyperkalaemia in people taking ACE inhibitors, ARBs, aldosterone antagonists or potassium-sparing diuretics; or • Combination of ACE inhibitor and ARB (at least one should be deprescribed) 2. Adverse effects potentially outweigh benefits: • Systolic blood pressure (SBP) < 150 mmHg in people aged ≥ 80 years (SBP < 140 mmHg if 75-79 years of age) and diastolic blood pressure (DBP) < 90 mmHg with any of the following: orthostatic hypotension/ recurrent falls /moderate-to-severe frailty assessed using validated tools/ life expectancy < 3 years • After a single episode of hyperkalaemia in people taking antihypertensive(s) commonly affect potassium levels (e.g. ACE inhibitors, ARBs, aldosterone antagonists or potassium-sparing diuretics) where the symptoms of heart failure or blood pressure can be controlled with other agents.
	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).
	CBR	We suggest continuing antihypertensives in people: • Who are robust, including those aged 85 years or older, if well tolerated, with the same target blood pressure as younger people • Taking beta-blockers for the management of AF at the lowest effective dose • Taking ACE inhibitors, ARBs, or beta-blockers for the management of heart failure • Taking ACE inhibitors or ARBs for renoprotection
	CBR	If deprescribing is unsuccessful despite two attempts, we suggest maintaining the lowest effective dose; however, we suggest reassessing the need for long-term therapy periodically.
	CBR	We suggest tapering beta blockers and centrally acting antihypertensives (e.g. methyldopa, moxonidine and clonidine) as they are more likely to lead to withdrawal symptoms (e.g. headache, palpitations, and tremors) or rebound hypertension when stopped abruptly.

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		In general, we suggest halving the daily dose every two weeks, ensuring individuals remain symptom-free and SBP < 150 mmHg in people 80 years or above (SBP < 140 mmHg if 75-79 years of age) and DBP < 90 mmHg before initiating each tapering. Once half the lowest standard dose formulation is reached, we suggest discontinuing completely and providing advice on lifestyle changes. For other antihypertensive drug classes, we suggest individualising the need for tapering depending on the drug class and the individual's response and tolerance.
	CBR	We suggest restarting antihypertensives if SBP is ≥ 150mmHg in people 80 years or above with moderate-to-severe frailty or a history of adverse effects (or SBP ≥ 140 if aged 75-79 years) and DBP is ≥ 90 mm Hg on three consecutive readings over four weeks. If SBP ≥ 180mmHg or DBP ≥ 110mmHg, restart immediately.
	CBR	For people taking multiple antihypertensives, we suggest deprescribing one medicine at a time. Priority should be given to antihypertensives with a higher risk of side effects. We suggest the following sequence for deprescribing: 1. Loop diuretics, centrally acting antihypertensives, peripheral vasodilators or alpha-blockers 2. Aldosterone antagonists 3. Beta-blockers, thiazide diuretics 4. Calcium channel blockers 5. ACE inhibitors, ARBs When two antihypertensives have a similar safety profile, the individual's preferences should guide the deprescribing process.
	CBR	We suggest advising people to self-monitor for orthostatic symptoms, angina symptoms, blood pressure, and heart rate at home by using a blood pressure monitor if people can use it correctly and to report unusual symptoms to their healthcare provider as needed. We suggest monitoring other drug-specific adverse drug withdrawal events such as palpitations (verapamil, diltiazem, beta-blockers), prostatism (alpha-blockers), or peripheral oedema and shortness of breath (diuretics).
	CBR	We suggest closely monitoring for fall risks and ongoing cardiovascular risk factors, at least monthly for the first six months after deprescribing, followed by monitoring every six months thereafter. However, this should be tailored based on individual factors such as their preferences, responses and tolerance to deprescribing. People at a higher risk of cardiovascular risk factors may require more frequent monitoring. We suggest offering advice on lifestyle optimisation for potentially modifiable cardiovascular risk factors.
Anti-inflammatory and antirheumatic products, non-steroids (NSAIDs)	CBR	Given the risk of gastrointestinal complications (e.g. severe esophagitis gastrointestinal ulcer, bleeding, perforation) as well as cardiovascular and renal adverse effects, we suggest deprescribing be offered to older people taking long-term NSAIDs.
	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).
	CBR	If deprescribing is unsuccessful despite multiple attempts, we suggest maintaining the lowest effective dose; however, we suggest only continuing NSAIDs in older people if the benefits of pain relief and improved function significantly outweigh the risks of gastrointestinal, cardiovascular, or renal adverse effects, particularly when: • Alternative pain management strategies are less effective or unavailable; and • The potential benefits and risks have been clearly communicated to the person; and

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		• There is appropriate monitoring of renal function and other risk factors, with periodic reassessment of the possibility of deprescribing.
	CBR	We suggest referral to other healthcare providers as needed for further evaluation and management, and/or considering safer alternatives for symptoms. Instead of oral NSAIDs, we suggest a judicious trial of intermittent or on-demand use of topical NSAIDs or other topical treatments for superficial localised painful conditions (e.g. knee osteoarthritis) for a short period, with monitoring of possible adverse effects and discontinuing use if not effective. If symptoms are persistent, we suggest adequate investigation and differential diagnoses and appropriate non-pharmacological therapies have been considered.
	CBR	We suggest individualised deprescribing based on the individual's preference. In general, we suggest discontinuing NSAIDs without the need for tapering; however, some people may prefer a gradual dose reduction of 25%-50% every one to two weeks. Once half the lowest standard dose formulation is reached, we suggest ceasing completely and switching to on-demand or intermittent use of NSAIDs at the lowest effective dose as well as providing advice for alternative pain management strategies (e.g. cognitive behavioural therapy, manual therapy, massages) and lifestyle interventions (e.g. exercise, weight management) if applicable. If symptoms recur during tapering, we suggest restarting therapy at approximately 50-75% of the previously tolerated dose and delaying further dose reductions by an agreed interval for stabilisation.
	CBR	We suggest advising patients to report to their healthcare professionals any symptoms of pain, changes in function or quality of life.
Antipsychotics	CBR	We suggest deprescribing be offered to older people who are taking antipsychotics when: • There is no clear indication, that a contraindication exists, or prescribing is inappropriate (e.g. use for vocal disruption or conditions other than primary psychotic illness). • Adverse effects or drug interactions outweigh potential benefits (e.g. Parkinson's disease or Lewy body dementia without psychotic symptoms, risk of QT prolongation, history of stroke, extrapyramidal side effects, recurrent falls, or significant weight gain). • Used for the management of changed behaviours beyond 12 weeks, if there is limited response to the treatment, symptoms have resolved, are unlikely to recur, or remain stable.
	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).
	CBR	**Changed behaviours** If deprescribing is unsuccessful despite multiple attempts and non-pharmacological options have been considered, we suggest maintaining the lowest effective dose, provided this aligns with the individual preferences, goals and overall treatment plans, and that the benefit clearly outweighs the harm and that potential underlying causes for changed behaviours (e.g. pain, constipation, depression) have been considered and/or addressed. However, we suggest reassessing the need for long-term therapy periodically

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		at least every three to six months or more frequently if symptoms change and additional monitoring for cardiometabolic risks in people using antipsychotics (weight, blood pressure, lipids, diabetes screening, cardiovascular risk calculation).
	CBR	We suggest individualising the tapering schedule and adjusting it according to the individual's response. In general, we suggest reducing the dose by 25% every one to four weeks, ensuring the absence of withdrawal symptoms and/or symptoms indicative of relapse before initiating further tapering. Once half the lowest standard dose formulation is reached, we suggest ceasing completely. However, smaller dose reductions may be appropriate or preferred by some individuals, particularly as lower doses are approached. In particular, for people at increased risk of withdrawal effects, such as those with prolonged use prior to withdrawal, high-dose regimens, or a prior history of withdrawal difficulties, slower individualised tapering strategies may be appropriate. This may include dose reductions of 5-10% at intervals of four weeks or longer, and consideration of doses below half the lowest commercially available strength.
	GPS	Healthcare providers should consider and offer adequate non-pharmacological management options such as psychosocial practices, structured care protocols, and sensory practices during and after deprescribing (ungraded good practice statement).
	GPS	Healthcare providers should consider and offer appropriate management strategies to the individual's families and care providers (e.g. verbal de-escalation, psychological intervention, increased staff-to-patient ratio, increased staff training in behaviour management (ungraded good practice statement).
	CBR	We suggest closely monitoring for individual responses and tolerance to antipsychotic tapering, paying specific attention to changes in psychological withdrawal effects (e.g. agitation, hallucinations, anxiety) and physical withdrawal symptoms (e.g. dyskinesia), function, and quality of life every one to two weeks following each dose adjustment until at least four weeks after the medicine is fully ceased if practical. After this initial period, we suggest monthly monitoring for at least three months, followed by monitoring every six months thereafter. However, this should be tailored based on individual factors such as their preferences, responses and tolerance to deprescribing. If in-person visits are impractical, we suggest advising people to report symptoms as needed.
	GPS	Healthcare providers should use validated assessment tools to evaluate changes in neuropsychiatric symptoms, functional status, and quality of life (e.g. Neuropsychiatric Inventory for neuropsychiatric symptoms, Functional Status Questionnaire for functional status, and EQ-5D for health-related quality of life) (ungraded good practice statement).
Antithrombotic agents	CBR	We suggest deprescribing be offered to older people taking anticoagulants: • For short-term indications (e.g. acute venous thromboembolism when anticoagulants have been taken for over 6-12 months in people without recurrent unprovoked venous thromboembolism or not at an increased risk of recurrence); or • When the risk of major/recurrent bleeding outweighs the benefit of prevention of ischaemic stroke or thromboembolism, following a shared informed decision-making process with the person and/or family/carers. We suggest deprescribing of warfarin be offered to older people with advanced chronic kidney disease (CKD IV-V/ESKD) as the risk of complications may outweigh the potential benefits of anticoagulation.
	CBR	We suggest deprescribing of antiplatelets be offered to older people: • Taking aspirin for the primary prevention of cardiovascular events due to the progressive reduction in net benefit relative to

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	increased risk of major bleeding in older people • Taking dual antiplatelet therapy for short-term indications (e.g. beyond 6-12 months post-acute coronary syndrome [or shorter duration in selected high bleeding risk populations); and continue with antiplatelet monotherapy) • Taking triple antithrombotic therapy [i.e. dual antiplatelet therapy plus an anticoagulant (for an oral anticoagulation indication such as atrial fibrillation)] beyond 1 to 4 weeks post-percutaneous coronary intervention; continue single antiplatelet therapy plus an anticoagulant for 6 to 12 months; then anticoagulant monotherapy for the long-term oral anticoagulation indication provided the person is stable and the risks of bleeding outweigh the benefits of continued dual therapy.
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).
CBR	We suggest continuing antithrombotics in robust older people with cardiovascular risk factors taking: • Anticoagulants for the primary prevention of thromboembolic events due to atrial fibrillation or secondary prevention of cardiovascular events • Extended anticoagulants for the secondary prevention of venous thromboembolism following recurrent unprovoked proximal deep vein thrombosis or pulmonary embolism, or in people who have persisting provoking factors • Antiplatelets for the secondary prevention of cardiovascular events (e.g. in people with coronary artery disease, peripheral artery disease or cerebrovascular disease) provided there are no life-limiting diseases (where potential risks often outweigh potential benefits) or significant bleeding risk, and this aligns with the individual's goals and preferences, following informed consent.
GPS	Healthcare providers should reassess an individual's cardiovascular and bleeding risk at least annually or more frequently, based on clinical indications or changes in health status, using a validated tool appropriate for the patient population (e.g. HAS-BLED for estimating major bleeding risk in people receiving anticoagulation for atrial fibrillation, and CHA2DS2-VASc for calculating stroke risk) (ungraded good practice statement).
CBR	We suggest ceasing anticoagulants and/or antiplatelets, without the need for tapering.
CBR	**Routine monitoring** We suggest close monitoring of ongoing risk factors (e.g. risk of bleeding and cardiovascular events), at least monthly for the first six months after deprescribing, followed by monitoring every six months thereafter to maintain the therapeutic relationship while working on potentially modifiable cardiovascular risk factors through lifestyle optimisation. However, this should be tailored based on individual factors such as their preferences, responses and tolerance to deprescribing. For warfarin, routine monitoring of the international normalised ratio (INR) when stopping is generally not required, especially if the INR is within the therapeutic range. However, closer monitoring (a few days after cessation) may be preferred if there are concurrent illnesses or medicine changes (including prescribed, over-the-counter medicines, complementary and alternative medicines). For people who need to restart warfarin therapy, closely monitoring the INR is essential to achieve the therapeutic range.
CBR	We suggest advising people to present for medical attention in case of concerning symptoms (e.g. dyspnoea, chest pain, or painful and/or swollen calf suggestive of venous thromboembolism).

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Benzodiazepine anxiolytics	CBR	Given the risk of dependence and other potential harm (e.g. falls, dependence, sedation) generally outweighs the potential benefits, we suggest deprescribing be offered to older people taking long-term (beyond four weeks) benzodiazepines, except in special circumstances, including but not limited to terminal care.
	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).
	CBR	If deprescribing is unsuccessful despite multiple attempts with considerations for non-pharmacological options (e.g. action plan for recurrence of anxiety symptoms), intermittent or "as-required" dosing, we suggest maintaining the lowest effective dose; however, we suggest reassessing the need for long-term therapy periodically.
	CBR	We suggest individualising the tapering schedule and adjusting it according to the individual's response. **In general,** we suggest reducing the dose by 25% every one to four weeks, ensuring the absence of withdrawal symptoms and/or symptoms indicative of relapse before initiating further tapering. Once half the lowest standard dose formulation is reached, we suggest ceasing completely. However, smaller dose reductions may be appropriate or preferred by some individuals, particularly as lower doses are approached. In particular, for people at increased risk of withdrawal effects, such as those with prolonged use prior to withdrawal, high-dose regimens, or a prior history of withdrawal difficulties, slower individualised tapering strategies may be appropriate. This may include dose reductions of 5-10% at intervals of four weeks or longer, and consideration of doses below half the lowest commercially available strength.
	GPS	Healthcare providers should consider and offer adequate non-pharmacological management options (e.g. psychological interventions for psychiatric disorders such as cognitive-behavioural therapy and relaxation techniques) during and after deprescribing (ungraded good practice statement).
	GPS	Healthcare providers should consider and offer appropriate management strategies to the individual's families and care providers (e.g. verbal de-escalation, psychological intervention, increased staff-to-patient ratio, increased staff training in behaviour management (ungraded good practice statement).
	CBR	We suggest closely monitoring for changes in anxiety symptoms, changes in psychological or physical health status, and quality of life every one to two weeks following each dose adjustment until at least four weeks after the medicine is fully ceased if practical. After this initial period, we suggest monthly monitoring for at least three months, followed by monitoring every six months thereafter. However, this should be tailored based on individual factors such as their preferences, responses and tolerance to deprescribing. If in-person visits are impractical, we suggest advising people to report symptoms as needed during monitoring.
Calcium/vitamin D	CBR	**Calcium supplementation** We suggest deprescribing calcium supplementation be offered to community-dwelling people* with a daily calcium dietary intake of > 1,300 mg. **Vitamin D supplementation** Given the limited evidence to support the routine use of vitamin D supplementation, we suggest deprescribing be offered to community-dwelling people* with optimal serum vitamin D concentrations (≥ 50 nmol/L) who are not at risk of vitamin D deficiency or fractures.

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		*Ongoing treatment recommended for people living in a residential aged care service
	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).
	CBR	**Calcium supplementation** We suggest continuing calcium supplementation in older people for long-term indications such as calcium used as a phosphate-lowering therapy in people with chronic kidney disease.
	CBR	**Vitamin D supplementation** We suggest continuing vitamin D supplementation, at optimal dosage, for long-term indications (e.g. calcitriol for the management of mineral and bone disease in chronic kidney disease, regardless of measured vitamin D levels).
	CBR	We suggest discontinuing calcium and vitamin D without the need for tapering.
	CBR	We suggest periodic monitoring for changes in dietary intake and/or sunlight exposure (taking into consideration seasonal changes) while working on potentially modifiable risk factors to reduce fall and fracture risk through other approaches (e.g. environmental changes, exercise).
Corticosteroids (skin)	CBR	To minimise potential adverse effects associated with prolonged use (i.e. skin atrophy, steroid rosacea), we suggest deprescribing be offered to older people using long-term topical corticosteroids for: 1. No ongoing indication (e.g. indication in line with current treatment guidelines) in people who are asymptomatic after uninterrupted treatment using appropriate potency therapy 2. Unclear or unknown indications
	GPS	Deprescribing decisions should be made in consultation with the person, their GP and/or specialist providers (e.g. dermatologist, clinical immunologist) to ensure it aligns with their preferences, goals and overall treatment plans (ungraded good practice statement).
	CBR	We suggest: • continuing the topical corticosteroid treatment during flares or at the first signs of a flare until resolution of symptoms; and • minimising exposure to topical corticosteroids by using the lowest potency topical corticosteroid that is effective, or intermittent use of higher potency topical corticosteroid if required; and • continuing the use of moisturisers.
	CBR	We suggest discontinuing topical corticosteroids without the need for tapering when the flare is fully resolved (e.g. itch-free, inflammation resolved) without strict time limits, then switch to on-demand or intermittent use for maintenance therapy if needed, following appropriate non-pharmacological management plan (e.g. use of emollient, avoid triggers) and flare management protocol is in place.
	CBR	We suggest advising individuals to report to their healthcare professionals symptoms of recurrence, noting topical corticosteroid withdrawal syndrome (e.g. red or darker burning skin, papulopustular rashes) is rare but more common in people stopping treatment after using for prolonged continuous periods of moderate-to-high potency topical corticosteroids, particularly on sensitive areas (e.g. face).

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Corticosteroids, plain (eye)	CBR	We suggest deprescribing be offered to older people using ophthalmic corticosteroids for over 6 to 8 weeks whose symptoms have resolved or are stable and are unlikely to recur (e.g. after post-operative healing).
	GPS	Deprescribing decisions should be made in consultation with the person and their treating ophthalmologist and/or optometrist to ensure it aligns with their preferences, goals and overall treatment plans (ungraded good practice statement).
	CBR	We suggest continuing ophthalmic corticosteroids in older people who have chronic steroid-responsive sight-threatening ophthalmic diseases (e.g. uveitis or chronic cystoid macular oedema) or who have previous corneal transplants or glaucoma incisional surgery to prevent corneal graft rejection and manage wound healing, with treatment and duration guided by the treating ophthalmologist and regular monitoring to balance benefits and risks.
	CBR	We suggest tapering ophthalmic corticosteroids in proportion to the duration of use and clinical indication. Short-term use (< 3 weeks) at usual doses generally does not require tapering. For treatment lasting three weeks or more, we suggest a gradual reduction in dosing frequency each week. If used for more than three months or in refractory disease, tapering should be even slower, by reducing frequency every two to four weeks. Tapering should be carried out by reducing the frequency of use rather than the number of drops, as patients should only instil one drop at a time. If rebound of inflammation or symptoms occur, return to approximately 75% of the previously tolerated dose until symptoms resolve and plan for a more gradual taper with the patient.
	CBR	We suggest close monitoring by the treating ophthalmologist and/or optometrist for rebound intraocular inflammation or symptom recurrence for two to four weeks after discontinuing ophthalmic corticosteroids, with longer monitoring for those with refractory disease or prolonged use. Beyond this period, ongoing monitoring should be determined using shared decision-making based on the severity of their condition and/or symptoms. We suggest advising patients to inform their healthcare providers of any concerning symptoms.
Denosumab/ Bisphosphonates	CBR	**Bisphosphonates** We suggest deprescribing be offered to older people who: • Develop contraindications during therapy, such as achalasia, Barrett's oesophagus, oesophageal scleroderma, certain gastric bypass procedures (e.g. Roux-en-Y), or chronic kidney disease (estimated glomerular filtration rate, eGFR <30 mL/min/1.73m2) • Experience adverse effects, including GORD or an inability to remain upright for 30 minutes after administration, increasing the risk of oesophageal irritation • Sustain an atypical femur fracture during therapy • Have a life expectancy of less than one year, unless bisphosphonates are essential (e.g. cancer management or secondary prevention in people at high risk of future fractures during their lifetime).
	CBR	**Bisphosphonates** We suggest offering a "drug holiday" to older people receiving long-term bisphosphonate treatment (5–10 years) who have no history of vertebral fractures, particularly those with a T-score ≥ –2.5, as the risk of rare but serious adverse events (e.g. atypical femoral fracture) may outweigh the benefits of continued treatment.
	CBR	**Denosumab** We suggest deprescribing be offered to older people:* • Experience denosumab-related side effects that impact quality of life (e.g. arthralgia, myalgia); or

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	• With advanced chronic kidney disease or are receiving dialysis due to the risk of severe hypocalcaemia; or • Sustain an atypical femur fracture during therapy. *Note that discontinuation of denosumab is associated with an increased risk of spontaneous vertebral fractures. Refer to the suggestions below for guidance on safe deprescribing, if deemed appropriate.
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).
CBR	**Bisphosphonates** We suggest continuing bisphosphonate therapy beyond 5–10 years in people with a T-score < –2.5 and/or a history of fragility fracture. For people who have discontinued bisphosphonates or are on a "drug holiday", we suggest consideration of restarting bisphosphonates if: • Bone loss of > 5% occurs, particularly at the hip • The person sustains a fracture following minimal trauma • The person has completed 3 to 5 years of a drug holiday, showed improvement during their initial treatment, and had no prior fractures.
CBR	**Denosumab** We suggest continuing denosumab in older people likely to derive a net benefit and have no significant adverse effects, even beyond 10 years, due to the increased risk of rebound vertebral fractures after discontinuation.
CBR	**Bisphosphonates** We suggest ceasing bisphosphonates without the need for tapering. Seek expert advice for antiresorptive therapy in the context of chronic kidney and end-stage kidney disease.
CBR	**Denosumab** We suggest transitioning to bisphosphonate therapy either 2 months before the next scheduled denosumab dose or at the time of the due dose and continuing for at least 12 months, due to the increased risk of rebound vertebral fractures following denosumab discontinuation or delayed administration.
CBR	We suggest closely monitoring for fracture risk using the Fracture Risk Assessment Tool and/or bone turnover markers, and the need for restarting therapy for osteoporosis in people not receiving therapy at a high risk of fracture, such as at least monthly for the first six months after deprescribing, followed by monitoring every six months thereafter to maintain the therapeutic relationship while working on lifestyle optimisation to reduce falls and fracture risk through multifactorial approach (e.g. environmental changes, exercise, nutrition).
CBR	We suggest monitoring requirements and monitoring intervals for C-terminal telopeptide (CTX) and procollagen type 1 N propeptide (P1NP) be guided by specialists.
CBR	We suggest assessing bone mineral density (BMD) with dual-energy X-ray absorptiometry (DXA) for men and women once, after 12 months of discontinuation of therapy, if clinically appropriate and feasible.

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		For people receiving antiresorptive treatment, we suggest monitoring BMD with DXA every two to five years when clinically appropriate, to evaluate treatment efficacy and the need for continued therapy, using the same instrument when possible. We suggest further assessment if BMD decreases by ≥ 5% at any major site or if a fracture occurs.
	CBR	For people receiving denosumab for osteoporosis, the optimal timing for elective invasive dental procedures remains uncertain and thus a referral to an endocrinologist may be considered. Although scheduling procedures immediately prior to the next dose has generally been recommended, it may be reasonable to schedule elective invasive dental procedures 6-8 weeks prior to the next scheduled dose to allow sufficient time for wound healing. We suggest against withholding the next scheduled dose of denosumab due to the risk of rebound fractures. We suggest a comprehensive dental review before initiating or reinitiating antiresorptive therapy due to the potential risk of medication-related osteonecrosis of the jaw.
Digoxin/Sotalol	CBR	**Digoxin** Given the risks of digitalis toxicity and drug-drug interactions potentially outweigh the benefits in older people, especially in those with declining renal function or polypharmacy, we suggest offering deprescribing digoxin: • For individuals with heart failure with reduced ejection fraction (HFrEF) who are in sinus rhythm and have been stabilised on one or more of the “four pillars” of the guideline-directed medical therapy (GDMT) • For individuals with atrial fibrillation treated with digoxin in combination with other agents (such as beta-blockers, diltiazem or verapamil) and have achieved the target heart rate [i.e. resting heart rate of < 110 beats per minute (bpm), or stricter control of < 80 bpm for those with persistent symptoms of atrial fibrillation especially breathlessness] • For individuals experiencing potential adverse effects (e.g. cardiac disturbances, gastrointestinal symptoms)
	CBR	**Sotalol** Given the risk of adverse effects (e.g. arrhythmia) potentially outweighing the benefits, we suggest deprescribing be offered to older people taking sotalol who: • Have permanent atrial fibrillation without an intention to restore or maintain sinus rhythm; or • Have been stabilised and in normal sinus rhythm for at least two to three months
	GPS	Deprescribing decisions should be made in consultation with the individual and their GP and/or specialist providers to ensure it aligns with their preferences, goals and overall treatment plans (ungraded good practice statement).
	CBR	We suggest continuing GDMT for heart failure or beta-blockers for atrial fibrillation.
	CBR	**Digoxin** We suggest individualising the tapering schedule based on the individual's clinical context. When digoxin is identified as being suitable for deprescribing, we suggest abrupt cessation if the serum level is subtherapeutic. We suggest abrupt cessation when clinically indicated, such as in cases of digitalis toxicity (e.g. bradycardia), and introducing an

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		alternative agent for rate control if indicated. If tapering is preferred and the individual is experiencing symptoms of tachycardia, we suggest reducing the dose by 50% every two weeks until the dose reaches ≤ 62.5 microgram, then cease completely.
	CBR	**Sotalol** We suggest gradual tapering of the dose by 25% every one to two weeks, ensuring individuals remain symptom-free before initiating each tapering. Once half the lowest standard dose formulation is reached, we suggest ceasing completely. If clinically indicated, consider an alternative for rate control, preferably a beta-blocker. Note: This suggestion does not apply to cases of sotalol poisoning, where urgent procedures are required to monitor and treat QT-interval prolongation and torsades de pointes. Refer to relevant clinician resources, such as the Therapeutic Guidelines toxicology section (https://www.tg.org.au/content-updates/toxicologyandtoxinology/).
	CBR	**Digoxin/Sotalol** We suggest closely monitoring for changes in heart rate and/or signs of cardiac decompensation (e.g. shortness of breath) including addressing electrolyte disturbances, every one to two weeks until at least four weeks after the medicine is fully ceased if practical. After this initial period, we suggest monitoring at three and six months, followed by monitoring every six months thereafter. However, this should be tailored based on individual factors such as their other medications, preferences, responses, and tolerance to deprescribing. If in-person visits are impractical, we suggest advising people to self-monitor symptoms using pulse monitors and report to their healthcare providers as needed.
Diuretics	CBR	Following shared decision-making, we suggest deprescribing of diuretics be offered to older people with: 1. No current indication (i.e. heart failure, renal failure, or hypertension) 2. Adverse effects potentially outweigh benefits (e.g. with urinary incontinence symptoms that significantly affect the quality of life) 3. When the diuretic was prescribed solely for hypertension and the criterion for deprescribing antihypertensive medications as outlined in the antihypertensives section is met 4. A relative contraindication, such as • Potassium-sparing diuretics in people with hyperkalaemia • Loop/thiazide diuretics in people with gout, refractory symptomatic hyponatremia, or diabetes mellitus • Diuretics for drug-induced oedema (e.g. calcium channel blockers)
	GPS	Deprescribing decisions should be made in consultation with the person and their GP and/or specialist providers (e.g. cardiologist or nephrologist) to ensure it aligns with their preferences, goals and overall treatment plans (ungraded good practice statement).
	CBR	We suggest continuing diuretics in older people taking long-term diuretics for persistently symptomatic fluid overload due to cardiac, renal, or liver failure, despite optimal management being in place.
	CBR	We suggest continuing aldosterone antagonists in people with heart failure, especially if reduced ejection fraction (HFrEF), given their benefit in reducing mortality and hospitalisation.
	CBR	We suggest continuing finerenone in chronic kidney disease (with albuminuria) in people with type 2 diabetes.

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	CBR	If deprescribing is unsuccessful despite two attempts, we suggest maintaining the lowest effective dose; however, reassessing the need for long-term therapy periodically.
	CBR	If complete cessation is considered appropriate, we suggest for furosemide: • If daily doses < 40mg, discontinue without tapering • If daily doses amount to 40mg, halve the dose for one week before complete cessation • If daily doses amount to 80mg, halve the dose for two weeks before complete cessation • If daily doses are between 80mg and 160mg, reduce the dose by 40 mg every two weeks until it reaches 40 mg, then discontinue completely. For other diuretics, we suggest tapering the dose with monitoring of fluid status, with daily weight monitoring for potential weight gain following down titration of dosing. For combination of thiazide and loop diuretic, we suggest first tapering thiazide diuretic.
	CBR	If potassium supplements are being used alongside thiazide or loop diuretics, we suggest adjusting or discontinuing potassium supplements in coordination with any changes to the diuretic therapy. For potassium-sparing diuretics, we suggest reviewing and adjusting other medicines and/or lifestyle factors that affect potassium levels in coordination with any changes to the diuretic therapy.
	CBR	We suggest closely monitoring for blood pressure, signs of exacerbations (e.g. peripheral oedema, signs of heart failure), and changes in body weight weekly during tapering for at least three months following deprescribing. After this initial period, we suggest monthly monitoring for ongoing risk factors for at least three months, followed by monitoring every six months thereafter. If in-person visits are impractical, we suggest advising people to self-monitor blood pressure and body weight at home by using a blood pressure monitor and weighing scales respectively, as well as reporting any significant changes to their healthcare provider as needed. If potassium supplements are being used alongside thiazide or loop diuretics, we suggest monitoring serum potassium levels at one week and two weeks and at least monthly thereafter if the level was outside the normal range when last checked.
	CBR	When discontinuing or changing the dose of diuretics, we suggest closely monitoring for changes in serum potassium and renal function (blood urea nitrogen, serum creatinine and eGFR).
Drugs used in benign prostatic hypertrophy (BPH)	CBR	We suggest deprescribing drugs used for benign prostatic hypertrophy (BPH) in people: • Whose symptoms have resolved or improved, such as those who have undergone transurethral resection of the prostate (TURP) or prostatectomy. • With adverse effects or interactions that outweigh the potential benefits (e.g. symptomatic hypotension)
	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).

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	CBR	We suggest continuing drugs used for BPH in older men with persistent and severe symptoms, with regular assessments to evaluate the need for ongoing therapy. For men who remain on alpha-blockers, we suggest periodic blood pressure monitoring alongside reviews of the long-term necessity of the treatment.
	CBR	If deprescribing is unsuccessful despite multiple attempts, we suggest maintaining the lowest effective dose, with periodic reassessment of the need for long-term therapy.
	CBR	We suggest deprescribing without the need for tapering; however, some patients may prefer gradual tapering by reducing the dose or dosing frequency per week that the medicine is taken. For individuals who continue to have mild to moderate symptoms, we suggest a trial of lifestyle modifications (e.g. limit fluid intake, limit bladder irritants, maintain a healthy weight) and behavioural strategies (e.g. timed voiding regimens, double-voiding techniques, pelvic floor exercises) before restarting pharmacological treatment.
	CBR	We suggest periodic evaluation of individual preferences and psychological effects of deprescribing, and advising individuals to report to their healthcare professionals any symptoms of recurrence or disease exacerbation (e.g. any return or worsening of urgency, frequency, incontinence, or nocturia) after stopping drugs used for BPH.
	GPS	Healthcare professionals should advise individuals to keep a record that they have taken drugs for BPH in the past if receiving eye surgery due to the risk of intraoperative floppy iris syndrome (ungraded good practice statement).
Drugs used in diabetes	GPS	HbA1c targets should be individualised based on individual factors and preferences, aiming to avoid hypoglycaemia (ungraded good practice statement). In general, we support the suggested HbA1c targets: • < 7.0 - 7.5% (53-58 mmol/mol) for robust older people (two or fewer coexisting chronic conditions and intact cognitive and functional status) • < 8.0% (64 mmol/mol) for older people with complex/intermediate health status (three or more coexisting chronic conditions requiring medicines/lifestyle interventions, two or more instrumental activities of daily living impairments, or mild-to-moderate cognitive impairment) • Avoid specifying strict HbA1c targets in older people with moderate-to-severe cognitive impairment, two or more impairments in activities of daily living, chronic illnesses with significant symptoms/impairment of functional status, or limited life expectancy (ungraded good practice statement). Medicines such as GLP-1 analogues, SGLT2 inhibitors, DPP-4 inhibitors and metformin can generally be used with minimal risks of hypoglycaemia, irrespective of the HbA1c (ungraded good practice statement).
	CBR	For older people using diabetes medicines to manage glycaemic control in type 2 diabetes mellitus (T2DM), we suggest offering deprescribing: 1. If the two most recent consecutive HbA1c levels are below the individualised target, prioritising deprescribing insulin therapy, then sulfonylureas next (given the higher risk of hypoglycaemia); or

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	2. In the presence of side effects impacting quality of life (e.g. infections attributed to SGLT2 inhibitors or other agents, gastrointestinal adverse effects, and weight loss attributed to metformin) where the benefit of discontinuation outweighs the risk.
CBR	In older people taking SGLT2 inhibitors or GLP-1 analogues for indications other than their glycaemic control benefits (e.g. **cardiovascular and/or renal risk reduction**), we suggest deprescribing be offered if these medicines are associated with adverse effects (e.g. potential muscle wasting which can exacerbate frailty), ensuring the benefit of discontinuation outweighs the risk and other management strategies are in place. If used for non-glycaemic indications as above, these medicines should be continued independent of the HbA1c with other medicines such as insulin and or sulfonylureas decreased and deprescribed if needed.
GPS	Deprescribing decisions should be made in collaboration with the individual and their diabetes care team, including specialist providers (ungraded good practice statement).
CBR	We suggest continuing diabetes medicines used for glycaemic management in older people who: • Have type 1 diabetes, other forms of diabetes such as latent autoimmune diabetes (LADA), or diseases of the exocrine pancreas (these should only be adjusted in consultation with the diabetes care team, including specialist providers); or • Experience hyperglycaemic symptoms and are not at an increased risk of hypoglycaemia; or • Are robust without reduced life expectancy and are not at an increased risk of hypoglycaemia.
CBR	Where appropriate, we suggest discontinuing oral diabetes medicines without the need for tapering with the possibility of restarting the medicine if needed, provided this approach aligns with the individual's goals and preferences, following informed consent. These should only be adjusted in consultation with the diabetes care team. Seek expert advice for the tapering of injectable diabetes medicines.
CBR	For people on combination therapy of diabetes medicines, we suggest: • Deprescribing one at a time; and • Prioritising medicines most likely to cause hypoglycaemia; and • Considerations be given to the impact of diabetes medicines on weight. These should only be adjusted in consultation with the diabetes care team. For instance, prioritising short-acting insulins and sulfonylureas and last for other agents with additional cardiovascular risk reduction if considered appropriate to deprescribe. In people taking other medicines that impact blood glucose levels (e.g. centrally acting medicines, beta-blockers, thiazide diuretics, antipsychotics, corticosteroids, quinolones, ACE inhibitors), we suggest close monitoring of blood glucose levels for the first two weeks when deprescribing diabetes medicines.
CBR	We suggest monthly monitoring of the overall risk-benefit profile and lifestyle changes for at least three months, then every six months thereafter. However, this should be tailored based on individual factors such as their preferences, responses and tolerance to deprescribing.

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		We suggest careful monitoring for signs and symptoms of hypoglycaemia and hyperglycaemia, as the presentation can often be different in older people and easily missed in older people.
	CBR	**Self-monitoring of blood glucose** For people who are already self-monitoring blood glucose, we suggest advising people to self-monitor random and fasting blood glucose levels at least once daily during tapering, and self-monitor for symptoms of hyperglycaemia (e.g. increased nocturia or thirst), as well as reporting to their healthcare provider if symptomatic or if their blood glucose levels become elevated. **HbA1c monitoring** We suggest reviewing HbA1c levels once after approximately three months, and then twice a year for people who are stable and well-managed.
	GPS	**Continuous glucose monitoring (CGM)** CGM should be considered and offered to people with diabetes to detect glucose fluctuations throughout the day, noting that CGM is not subsidised by the National Diabetes Services Scheme for individuals who do not have Type 1 diabetes at the time of writing. Where it is safe to do so, de-escalate blood glucose monitoring in line with patient preferences and goals of treatment to reduce the daily burden of disease monitoring (ungraded good practice statement).
	GPS	Healthcare providers should reinforce the benefits of optimal dietary intake and physical activity (ungraded good practice statement).
Estrogen	CBR	**Systemic Menopausal Hormone Therapy (MHT)** We suggest deprescribing be offered to older women taking MHT (menopausal hormone therapy i.e. estrogen monotherapy or estrogen combined with progestogen) whose menopausal symptoms have resolved or improved over time, provided this aligns with the individual's goals and preferences and following informed consent. **Vaginal MHT** We suggest deprescribing be offered to older women on low-dose vaginal estrogen therapy for genitourinary syndrome of menopause whose symptoms have resolved or improved over time.
	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).
	CBR	We suggest continuing MHT in people who experience symptoms recurrence that impact their quality of life and cannot be managed with non-hormonal options. If deprescribing is unsuccessful, we suggest non-hormonal and non-pharmacological therapies (e.g. lifestyle interventions) for genitourinary syndrome of menopause such as moisturisers, lubricants or pelvic floor muscle exercises may be considered as alternative options before considering the reinitiation of MHT. If MHT needs to be resumed, we suggest maintaining the lowest effective dose; however, we suggest reassessing the need for long-

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		term therapy periodically including the possibility of switching to another route of administration (e.g. topical low-dose estrogen intravaginal cream for localised symptoms).
	CBR	We suggest stopping MHT abruptly without the need for tapering; however, some patients may prefer gradual tapering by reducing the dose or dosing frequency. For oral formulations, we suggest reducing one dose per week every two to four weeks (e.g. reducing from daily administration to six days a week with one day off for two to four weeks, then to five days a week for two to four weeks, and so on, until discontinuation). For transdermal formulations, we suggest gradually reducing the strength of the patch over three to six months, depending on the available preparations. For gel, cream or pessary formulations, we suggest tapering by reducing the dosing frequency every two to four weeks.
	CBR	We suggest periodic evaluation of patient preferences, symptom control and ongoing benefit-risk profile including fracture risk (e.g. using Fracture Risk Assessment Tool) and if indicated, bone mineral density, as well as consideration for alternative treatments for management of osteoporosis if required.
Iron/Vitamin B12	CBR	If haemoglobin and ferritin/B12 levels are within an acceptable range, we suggest deprescribing be offered to older people taking iron and/or vitamin B12: 1. Without an ongoing indication (e.g. underlying cause of iron deficiency has been addressed) 2. For drug-induced indication where the original drug can be suitably reduced, discontinued, or replaced by another drug (e.g. inappropriate prescribing cascade related to metformin or proton pump inhibitors and B12) 3. With no clear or known indication (e.g. no documented history of iron/B12 deficiency or pernicious anaemia)
	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).
	CBR	We suggest continuing iron or vitamin B12 therapy in older people whose deficiency is due to permanent underlying conditions, such as a history of gastric surgery, pernicious anaemia, or unmodifiable dietary limitations (e.g. vegetarian or vegan diet).
	CBR	We suggest ceasing iron and/or vitamin B12 therapy without the need for tapering. We suggest before deprescribing, assessing nutritional status and other relevant health factors, as part of a comprehensive care plan to ensure ongoing patient well-being.
	CBR	We suggest offering laboratory monitoring of complete blood count, iron studies/B12 periodically (e.g. 11 months after discontinuation as per the Medicare Benefits Schedule or sooner if symptoms arise) to promptly identify any recurrence of iron/B12 deficiency.
	CBR	We suggest advising patients to report to their healthcare providers symptoms of iron/B12 deficiency such as unexplained lack of energy, shortness of breath, headache, and heart palpitations, or B12 deficiency symptoms of glossitis (tongue soreness), and neuropathy (numbness involving fingers/toes).

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Levodopa	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 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).
	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.
	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.
	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.
Levothyroxine	GPS	The target TSH concentration should be individualised for older adults; in general, targeting a reference range of 1-5 mU/L for people aged 65 to 80 years, and 4 to 6 mU/L for people aged 80 years and older (ungraded good practice statement).
	CBR	To minimise potential adverse effects associated with overtreatment, especially related to cardiovascular events and loss of bone mass in older people, we suggest deprescribing be offered to older people taking long-term levothyroxine: 1. Who are asymptomatic and stable on a low dose (e.g. 25 to 50 microgram); 2. For unclear/unknown indication or no clear evidence of clinical benefit (e.g. subclinical hypothyroidism); or 3. For drug-induced indication where the original drug can be suitably reduced, discontinued, or replaced by another drug e.g. inappropriate prescribing cascade with e.g. • Lithium • Amiodarone (taking into consideration the possible long half-lives)
	GPS	Deprescribing decisions should be made in consultation with the person and their GP and/or endocrinologist to ensure it aligns with their preferences, goals and overall treatment plans (ungraded good practice statement).
	CBR	We suggest continuing long-term levothyroxine for autoimmune conditions (e.g. Hashimoto thyroiditis), radioactive iodine treatment and thyroidectomy where the benefits of continuing treatment potentially outweigh the potential risks, with periodic re-assessment of thyroid function every 6 to 12 months.
	CBR	If the serum TSH concentration increases (primary hypothyroidism) or if the free serum T_4 concentration falls below the reference range without an elevated TSH (central hypothyroidism) during deprescribing, we suggest restarting levothyroxine at the previously tolerated dose.
	CBR	We suggest reducing the dose by approximately 50% if the baseline TSH concentration is within an acceptable range. After six weeks, if the TSH concentration remains within an acceptable range, discontinue the thyroid therapy completely. After another six weeks, if the TSH concentration remains within an acceptable range, measure the free thyroxine (T4) level. If the free T4 concentration is

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		within an acceptable range, there is no need to restart thyroid hormone therapy. After a further six weeks, measure the final TSH concentration.
	CBR	We suggest closely monitoring for potential symptoms of hypothyroidism (e.g. fatigue, weight gain, cold intolerance, poor mental concentration, mood changes) during deprescribing by advising people to report symptoms to their healthcare providers. We suggest reviewing TSH and/or free serum T4 concentrations six weeks after each dose adjustment, as levothyroxine has a long half-life and TSH concentrations take 6-8 weeks to stabilise; however, this review should be tailored to individual factors, such as the patient's preferences, response, and tolerance to deprescribing.
Lipid-modifying agents	CBR	Following a shared decision-making discussion in which potential benefits and harms are clearly communicated along with considerations of other individual factors, we suggest deprescribing be offered to older people taking lipid-modifying agents: 1. For primary prevention of cardiovascular diseases (CVD) and cerebrovascular diseases in people aged*: • 65-79 with CVD risk < 5% (over five years) • 65-79 with CVD risk between 5% and < 10% (over five years) and, if tested, a coronary artery calcium score of zero and/or no coronary artery disease shown on computed tomography (CT) or invasive coronary angiogram • ≥ 80 where the risk of adverse effects potentially outweighs the benefit 2. For secondary prevention in people aged ≥ 80 years unable to tolerate high-intensity statin, moderate-intensity therapy can be considered 3. For primary or secondary prevention in the context of frailty or advanced life-limiting illness (e.g. poor prognosis malignancies) with a life expectancy < 12 months when there are no recent active cardiovascular diseases to reduce risk of adverse effects, reduce medication burden, and improve quality of life 4. With possible adverse effects (e.g. statin-related muscle symptoms such as myalgia, myopathy, rhabdomyolysis) *See the GPS below on the suggestion to assess cardiovascular risk over five years
	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	Healthcare providers should use the Australian CVD Risk Calculator* to assess cardiovascular risk over the next five years, as it accounts for the specific contexts of the Australian population and healthcare system (https://www.cvdcheck.org.au/calculator) (ungraded good practice statement). *Note that the Australian cardiovascular disease risk calculator is validated for use in people without known CVD aged 30 to 79 years who do not already meet high risk criteria.
	CBR	We suggest considering ongoing statin therapy in individuals whose life expectancy is sufficient to allow time to benefit from continued treatment, and who are taking statins for: 1. Primary prevention of CVD and cerebrovascular disease in line with current treatment guidelines, e.g. • People aged 65-79 with a high CVD risk ≥ 10% (over 5 years)

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		• With a coronary artery calcium score > 100 • With total cholesterol levels above 7.5mmol/L, independent of their CVD risk • With familial hypercholesterolaemia 2. Secondary prevention of CVD and cerebrovascular disease provided this aligns with the individual's goals and preferences, following informed consent.
	CBR	We suggest discontinuing lipid-lowering agents without the need for tapering provided it aligns with the individual's wishes and goals.
	CBR	We suggest monitoring lipid concentrations annually.
Macrogol laxatives	CBR	To minimise the risk of electrolyte imbalance (particularly for the use of macrogol with electrolytes in people with congestive heart failure, renal disease, or severe dehydration), we suggest deprescribing be offered to older people taking long-term macrogol laxatives: 1. Without an ongoing indication in people who are/have been asymptomatic 2. For drug-induced constipation where the original drug can be suitably reduced, discontinued, or replaced by another drug (e.g. inappropriate prescribing cascade)
	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).
	CBR	We suggest continuing macrogol laxatives when there is a clear indication (e.g. opioid-induced constipation for the duration of opioid treatment, chronic slow-transit constipation), provided this aligns with the individual's goals and preferences, following informed consent.
	CBR	If deprescribing is unsuccessful despite multiple attempts, we suggest maintaining the lowest effective dose; however, reassessing the need for long-term therapy periodically.
	CBR	We suggest individualising the tapering schedule and adjusting it according to the individual's current bowel function, risk of recurrence, frequency and consistency of the stools. In general, given the likelihood of recurrence of constipation, we suggest reducing by one sachet and then alternate day dosing every one to two weeks and switching to on-demand or intermittent use at the lowest effective dose. Once dosing every other day and regular bowel movements occur without difficulty, discontinue the medicine. If constipation recurs during tapering, we suggest restarting at the previously tolerated tapered dose or original dose until constipation is resolved, delaying further dose reductions by an agreed interval for stabilisation, and planning for a more gradual taper. For people on combination therapy of laxatives, we suggest deprescribing one at a time, prioritising medicines with a higher risk of harm and a lower potential benefit from continued use. However, the dose for concomitant laxatives may also need to be adjusted

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		temporarily to compensate for the lower dose of the other agent. We suggest individualising the tapering schedule and adjusting it according to the individual factors above.
	GPS	Healthcare providers should offer appropriate education on fluid intake, fibre intake, mobility and referral to other relevant healthcare providers whenever applicable (ungraded good practice statement).
	CBR	We suggest closely monitoring for recurrence of constipation following each dose adjustment and advising people that they may revert to the previously tolerated tapered dose or original dose if constipation recurs. We suggest monitoring for changes in mobility, fluid and fibre intake and adapting strategies to deprescribing as appropriate.
Medicines for chronic obstructive airway diseases	CBR	Given the risk of adverse effects associated with prolonged ICS treatment potentially outweighing the benefits in people at low risk of COPD exacerbation, we suggest deprescribing of inhaled corticosteroids (ICS) be offered to older people who have been using triple therapy (long-acting muscarinic antagonist + long-acting beta$_2$-agonist + ICS) for stable chronic obstructive pulmonary disease (COPD) **without** a severe exacerbation requiring hospitalisation, or less than two moderate exacerbations in the past 12 months.
	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).
	CBR	We suggest continuing maintenance therapy as appropriate with a long-acting bronchodilator(s) (e.g. long-acting muscarinic antagonist, long-acting beta2 agonist), either as monotherapy or in combination depending on symptomatic response.
	CBR	We suggest individualised deprescribing based on the individual's preference. In general, we suggest discontinuing ICS without the need for tapering; however, some people may prefer a gradual stepwise reduction.
	GPS	Healthcare providers should regularly check inhaler techniques and adherence, especially if symptoms remain persistent (ungraded good practice statement).
	GPS	In severe disease, consideration should be given to which inhaler is used (i.e. insufficient airflow to utilise a dry powder Ellipta device vs. a jet Respimat device) (ungraded good practice statement).
	GPS	Healthcare providers should consider and offer adequate education on lifestyle interventions (e.g. smoking cessation, nutrition, alcohol, physical activity) to individuals as appropriate (ungraded good practice statement).
	GPS	Pulmonary rehabilitation should be offered to all people with COPD and may result in significant quality of life and symptom improvements to offset any anxiety around deprescribing (ungraded good practice statement).
	CBR	We suggest monitoring lung function using a spirometry test three to six months after deprescribing, or sooner if clinical deterioration.
	CBR	We suggest closely monitoring for changes in symptoms and quality of life every six weeks for the first six months after deprescribing, then monitoring for exacerbation frequency every six months thereafter, with cough and shortness of breath most likely for the first three months of withdrawal.
Ocular lubricants	CBR	We suggest deprescribing be offered to older people taking long-term ocular lubricants whose symptoms have resolved or are stable and are unlikely to recur, particularly if an avoidable or modifiable risk factor (e.g. drug-induced dry eyes) has been addressed.
	GPS	Deprescribing decisions should be made in consultation with the person and their treating ophthalmologist and/or optometrist where appropriate to ensure it aligns with their preferences, goals and overall treatment plans (ungraded good practice statement).

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	CBR	We suggest continuing long-term ocular lubricants (preservative-free if possible) at the lowest effective dose and with appropriate formulations, particularly if other non-pharmacological strategies are less effective, environmental triggers cannot be avoided (e.g. living conditions), or if patients have concurrent ocular conditions/taking concomitant medicines which are known to cause dry/irritated eyes.
	CBR	We suggest gradually tapering doses before ceasing if more than daily administration (e.g. twice or three times daily), then switching to "as required" use at the lowest effective dose as well as providing advice for alternative management strategies, provided this aligns with the individual's goals and preferences, following informed consent.
	CBR	We suggest ongoing monitoring for any ocular symptoms such as dry eyes, redness, and discomfort in the eyes for three to six months after deprescribing by advising patients to report to their healthcare providers any concerning symptoms in between appointments. If symptoms are persistent, we suggest adequate investigation (including administration technique) and differential diagnoses and considering appropriate non-pharmacological therapies.
Organic nitrates	CBR	We suggest deprescribing be offered to older people taking long-acting nitrates in combination with beta-blockers or calcium channel blockers for stable coronary heart diseases who have not experienced angina symptoms or have not required short-acting nitrates for at least six months.
	GPS	Deprescribing decisions should be made in consultation with the individual and their GP and/or specialist providers to ensure it aligns with their preferences, goals and overall treatment plans (ungraded good practice statement).
	CBR	We suggest short-acting nitrates be offered to people for acute relief should angina symptoms occur.
	CBR	If deprescribing is unsuccessful despite one attempt, we suggest maintaining the lowest effective dose; however, we suggest reassessing the need for long-term therapy periodically.
	CBR	In general, we suggest tapering the dosage and ensuring that short-acting nitrates are available should symptoms occur. For oral formulations, gradually reduce the dose, such as from 120mg daily to 60mg daily, to 30mg daily, then finally discontinue completely. For transdermal formulations, gradually reduce the dose, such as from 15 mg/24 hours to 10 mg/24 hours, to 5 mg/24 hours, then finally discontinue completely. If symptoms recur, we suggest restarting long-acting nitrates at the previously tolerated dose, delaying further dose reductions by an agreed interval for stabilisation, and planning for a more gradual taper if appropriate.
	CBR	We suggest monitoring for blood pressure or recurrence of angina symptoms (e.g. weekly for at least two weeks after withdrawal) tailoring the approach to individual factors such as preferences, responses, and tolerance to deprescribing. If in-person visits are impractical, we suggest advising people to report symptom recurrence as needed (e.g. telehealth).
Potassium	CBR	To minimise potential prescribing cascades and risk of adverse outcomes associated with electrolyte imbalance, especially in people with an increased risk of hyperkalaemia (e.g. renal impairment, concurrent use of medicines affecting serum potassium levels), we suggest deprescribing be offered to older people taking long-term potassium: 1. Without an ongoing indication (e.g. past use for diuretic-induced hypokalaemia and current normal serum potassium)

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		2. For drug-induced hypokalaemia where the original drug can be suitably reduced, discontinued, or replaced by another drug (e.g. inappropriate prescribing cascade) 3. With no clear or known indication (e.g. prophylaxis in people with a low risk of hypokalaemia)
	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).
	CBR	We suggest continuing potassium in older people with persistent potassium depletion due to causes that cannot be resolved: • Advanced liver disease; or • Secondary hyperaldosteronism with renovascular hypertension; or • Gastrointestinal losses; or • Concomitant medicines known to affect potassium status adversely that cannot be deprescribed provided treatment aligns with the individual's goals and preferences, following informed consent.
	CBR	We suggest discontinuing potassium without the need for tapering with the possibility of restarting if needed. If tapering is preferred [e.g. for people taking a high dose (i.e. > 1200 mg three times daily) prior to deprescribing], we suggest reducing the dose by 50%* every two weeks to minimise the risk of hypokalaemia. Once the lowest dose is reached, we suggest discontinuing potassium completely. *Tapering can be performed by reducing the dosing frequency. Effervescent tablet formulation is available, presenting additional options for tapering doses.
	CBR	We suggest closely monitoring serum potassium concentration with the time frame to be determined by the baseline dose. In general, we suggest reassessing serum potassium concentration once, one week after deprescribing. We suggest periodic monitoring for dietary changes (i.e. intake of potassium-containing foods), and symptoms or signs attributable to hypokalaemia (e.g. muscle weakness, cramps, spasms, fatigue, and palpitations).
Prednisone/ Prednisolone	CBR	We suggest deprescribing be offered to older people taking long-term oral corticosteroids for: • Chronic obstructive pulmonary disease (COPD) as long-term oral corticosteroids are not indicated for this condition; or • Autoinflammatory or autoimmune conditions, once clinical remission or sustained low disease activity has been achieved; or • Polymyalgia rheumatica, after at least 12 months of therapy and lack of signs and symptoms of an active disease.
	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).
	CBR	We suggest that ongoing treatment with oral corticosteroids may be necessary for some people with autoimmune diseases who experience a relapse after attempts to deprescribe, despite concurrent use of disease-modifying agents. In such cases, we suggest maintaining long-term oral corticosteroids at the lowest effective dose.
	CBR	We suggest individualising the tapering schedule and adjusting the schedule based on individual preferences, overall risk of withdrawal effects, risk of glucocorticoid-induced adrenal insufficiency, risk of relapse, adverse drug effects, disease activity, the initial dose, and duration of use.

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		In general, we suggest reducing the dose by prednisone equivalent of 10-20% per week; however, some people may require very gradual tapering such as 1 mg every four to eight weeks, especially when approaching physiological glucocorticoid dosing.
	CBR	We suggest advising patients to report to their healthcare providers symptoms of potential signs and symptoms of glucocorticoid withdrawal syndrome (e.g. sleep disturbance and mood changes), glucocorticoid-induced adrenal insufficiency (e.g. myalgias, fatigue, and muscle weakness) and recurrence of underlying conditions (e.g. breathlessness for COPD or arthralgias in rheumatoid arthritis). We suggest monthly monitoring of erythrocyte sedimentation rate and C-reactive protein for at least three months, followed by monitoring every six months thereafter. However, this should be tailored based on individual factors such as their preferences, responses and tolerance to deprescribing.
Prochlorperazine	CBR	We suggest deprescribing be offered to older people taking long-term prochlorperazine: 1. Originally for a short-term indication (e.g. symptoms of acute vertigo typically resolve within hours to days); or 2. With no clear or known indication; or 3. For the indication of drug-induced nausea and vomiting/dizziness, where the original drug can be suitably reduced, discontinued, or replaced by another drug (e.g. inappropriate prescribing cascade)
	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).
	CBR	Given the harms of long-term prochlorperazine use are likely to outweigh the benefits in most cases, we generally suggest against the use of long-term prochlorperazine in older people and trial on-demand or intermittent use at the lowest effective dose in addition to appropriate investigation to identify and subsequently treat a cause. If symptoms are chronic and persistent, we suggest considering appropriate non-pharmacological therapies and/or safer alternatives for symptoms, provided this aligns with the individual's goals and preferences, following informed consent.
	CBR	We suggest individualising the tapering schedule and adjusting it according to the individual's response. In general, given the likelihood of symptom recurrence in long-term users, we suggest reducing the dosing frequency every one to two weeks: • For those on three times daily, reduce to twice daily, then once daily, then cease completely; or • For those on twice daily, reduce to once daily, then cease completely and switch to on-demand or intermittent use at the lowest effective dose. If symptoms recur during tapering, we suggest restarting at the previously tolerated tapered dose until symptoms resolve, delaying further dose reductions by an agreed interval for stabilisation, and planning for a more gradual taper.
	CBR	We suggest closely monitoring for disease exacerbations (e.g. symptoms recurrence) or adverse drug withdrawal events (ADWEs, e.g. withdrawal-emergent abnormal movements), every two weeks following each dose adjustment until at least four weeks after the medicine is fully ceased if practical. After this initial period, we suggest monthly monitoring for at least three months, followed by

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		monitoring every six months thereafter. However, this should be tailored based on individual factors such as their preferences, responses and tolerance to deprescribing. For persistent ADWEs, we suggest collaborating with other relevant healthcare providers (e.g. physiotherapist and speech pathologist) to evaluate their impact and seriousness and develop strategies to resolve them. If in-person visits are impractical, we suggest informing people to report symptom recurrence (e.g. dizziness) and/or any appearance of new symptoms as needed.
Proton-pump inhibitors	CBR	Given the potential adverse effects associated with prolonged use (i.e. infections, nutritional deficiencies, fractures), we suggest deprescribing be offered to older people taking PPIs: 1. Originally for a short-term indication i.e. • Up to 8 weeks for gastroesophageal reflux disease (GORD) • Up to 12 weeks for peptic ulcer disease • Up to 2 weeks for uncomplicated H. pylori eradication (as part of the eradication regimen) • During an intensive care unit admission for stress ulcer prophylaxis 2. Without a clear or known indication
	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).
	CBR	In people with complicated gastrointestinal pathologies (e.g. Barrett's oesophagus, severe erosive disease) or those with a high risk of gastrointestinal complications using PPI for gastroprotection, we suggest continuing PPI therapy on the lowest effective dose according to the clinical indication, individual tolerance, and responses, provided this aligns with the individual's goals and preferences, following informed consent.
	CBR	If deprescribing is unsuccessful despite multiple attempts, taking into account the possibility of rebound acid hypersecretion (occurred typically within four to eight weeks after PPI discontinuation), we suggest maintaining the person on the lowest effective dose; however, reassessing the need for long-term therapy periodically.
	CBR	We suggest individualising the tapering schedule and adjusting it according to the individual's response. In general, we suggest reducing the dose by 50% every two weeks (noting that enteric-coated formulations should not be broken*), ensuring individuals remain symptom-free before initiating each tapering. Once half the lowest standard dose formulation is reached, we suggest switching to alternate-day dosing or discontinuing PPI therapy completely and switching to on-demand or intermittent use of PPIs, antacids, alginates, or H2 receptor antagonists (H2RAs) at the lowest effective dose. We suggest a slower tapering for people taking a high dose (e.g. 20 mg omeprazole twice daily) prior to deprescribing to minimise rebound acid hypersecretion.

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		If symptoms recur during tapering, we suggest restarting PPIs at the previously tolerated dose until symptoms resolve or using an antacid, alginate, or H2RAs as a "rescue therapy" for occasional symptoms, delaying further dose reductions by an agreed interval for stabilisation, and planning for a more gradual taper. *Marketed PPI dose forms that may be simpler to titrate include dispersible enteric tablets (omeprazole and esomeprazole), orally disintegrating tablets (lansoprazole), oral liquids (omeprazole) and granules (pantoprazole).
	CBR	For people on combination therapy of PPI and either an antacid or H2RA, we suggest deprescribing one at a time, prioritising antacids and then H2RAs as these are typically associated with a lower risk of harm when discontinued compared to PPIs and can be used as "rescue therapy" for occasional symptoms while tapering PPIs. Tapering of H2RAs can generally follow the same approach as PPI tapering (i.e. halving the dose every two weeks); however, we suggest individualising the tapering schedule and adjusting it according to the individual's response. Antacids and alginates typically do not require tapering unless used regularly and following patient preference. The dose for concomitant acid suppressants may also need to be adjusted temporarily to compensate for the lower dose of the other agent.
	GPS	Healthcare providers should offer education on diet and lifestyle modifications (or referral to other relevant healthcare providers) and clearly differentiate between symptom recurrence or exacerbation due to lifestyle factors and adverse drug withdrawal events (ungraded good practice statement).
	CBR	We suggest closely monitoring for disease exacerbations (e.g. symptom recurrence) or adverse drug withdrawal events (e.g. rebound acid hypersecretion), every two weeks following each dose adjustment until at least eight weeks after the medicine has fully ceased, if practical. After this initial period, we suggest monthly monitoring for at least three months, followed by monitoring every six months thereafter. However, this should be tailored based on individual factors such as their preferences, responses and tolerance to deprescribing. If monitoring visits are impractical, we suggest advising people to report symptom recurrence (e.g. acid-related gastrointestinal symptoms) and/or any appearance of new symptoms as needed.
	GPS	In individuals with recurrent symptoms after deprescribing, healthcare providers should test for H. pylori infection and proceed with eradication if the infection is present (ungraded good practice statement).
Sedative hypnotics	CBR	We suggest deprescribing be offered to older people taking long-term (beyond four weeks) benzodiazepines for insomnia as the risk of dependence and other potential harm (e.g. falls, fractures, impaired cognition) generally outweighs the potential benefits, except in special circumstances (e.g. terminal care).

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	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).
	CBR	Given the harms of long-term use are likely to outweigh the benefits in most cases, we generally suggest against the use of long-term benzodiazepines for insomnia in older people and trial on-demand or intermittent use at the lowest effective dose in addition to appropriate investigation to identify and subsequently treat a cause. If symptoms are chronic and persistent, we suggest considering appropriate non-pharmacological therapies and/or safer alternatives for symptoms, provided this aligns with the individual's goals and preferences, following informed consent.
	CBR	We suggest individualising the tapering schedule and adjusting it according to the individual's response. In general, we suggest reducing the dose by 25% every one to four weeks, ensuring the absence of withdrawal symptoms or reduced sleep quality before initiating further tapering. Once half the lowest standard dose formulation is reached, we suggest ceasing completely. However, smaller dose reductions may be appropriate or preferred by some individuals, particularly as lower doses are approached. In particular, for people at increased risk of withdrawal effects, such as those with prolonged use prior to withdrawal, high-dose regimens, or a prior history of withdrawal difficulties, slower individualised tapering strategies may be appropriate. This may include dose reductions of 5-10% at intervals of four weeks or longer, and consideration of doses below half the lowest commercially available strength.
	GPS	Healthcare providers should consider and offer adequate non-pharmacological management options (e.g. good sleep practices) as appropriate (ungraded good practice statement).
	CBR	We suggest closely monitoring for withdrawal symptoms and/or symptoms indicative of relapse, including worsening sleep quality, changes in psychological or physical health status (e.g. anxiety, and agitation) and quality of life every one to two weeks following each dose adjustment until at least four weeks after the medicine is fully ceased if practical. After this initial period, we suggest monthly monitoring for at least three months, followed by monitoring every six months thereafter. However, this should be tailored based on individual factors such as their preferences, responses and tolerance to deprescribing. If in-person visits are impractical, we suggest advising people to report symptoms as needed.
Teriparatide	CBR	We suggest deprescribing be offered to older people who have been taking teriparatide for 24 months or longer* due to the limited efficacy and safety data beyond 24 months of continuous treatment or reinitiation of treatment; however, the duration of therapy should be guided by individual factors and informed consent. *Teriparatide is approved for 24 months lifetime use in Australia with Pharmaceutical Benefits Scheme subsidisation for 18 months per lifetime per person.
	GPS	Deprescribing decisions should be made in consultation with the person and their specialist providers to ensure it aligns with their preferences, goals and overall treatment plans (ungraded good practice statement).
	CBR	For postmenopausal women and men discontinuing teriparatide, we suggest transitioning to bisphosphonate therapy for at least 12 months. If bisphosphonates are contraindicated or not tolerated, alternative antiresorptive therapy should be considered.
	CBR	We suggest ceasing teriparatide without the need for tapering.

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	CBR	We suggest closely monitoring for fracture risk using the Fracture Risk Assessment Tool and/or bone turnover markers, and the need for restarting therapy for osteoporosis in people not receiving therapy at a high risk of fracture, such as at least monthly for the first six months after deprescribing, followed by monitoring every six months thereafter to maintain the therapeutic relationship while working on lifestyle optimisation to reduce falls and fracture risk through multifactorial approach (e.g. environmental changes, exercise, nutrition). We suggest assessing bone mineral density by using dual-energy X-ray absorptiometry for men and women once after 12 months of discontinuation of therapy.

CBR, consensus-based recommendation; GPS, good practice statement; GP, general practitioner
Consensus-based recommendations (CBRs) are developed following a systematic review when the certainty of evidence, assessed using the GRADE approach, is low or very low. Good practice statements (GPS) are not derived directly from a systematic review but are formulated to support recommendations or guide deprescribing when indirect yet high-quality evidence exists and GPS criteria are met.

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For referencing supporting evidence and further information, see the full guideline PDF available at deprescribing.com or scan the QR code below: