**Annex: 5-step Deprescribing Process**

**Acid suppressants: Proton pump inhibitors**

Step 1: Perform a comprehensive patient medical and medication history

**Steps 2, 3: Consider overall risk/appropriateness of drug and assess if drug can be discontinued *(Tick where appropriate)***

\_\_Lack of clear indication: E.g., Barrett’s esophagus, Zollinger-Ellison syndrome, dyspepsia\*, GERD\*, peptic ulcer disease\*, H. pylori eradication\*, dual antiplatelets or prevention of NSAID-induced ulcers in high-risk patients#

*\*use for less than 12 wks #>65yo; history of PUD/GI bleed; concurrent use of anticoagulants, steroids, low-dose aspirin or antiplatelets*

\_\_Symptoms have been resolved; Drug causing the symptoms has been ceased

\_\_Multiple drugs prescribed for same indication; Pls specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Drug interaction/Contraindication; Pls specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Lack of drug effectiveness for symptomatic relief

\_\_Preference of patient/caregiver (e.g., adherence issues); Pls specify:\_\_\_\_\_\_

**Step 4: Plan and initiate drug withdrawal**

* **Decision whether to deprescribe: Yes/No *(Circle the appropriate option)* If No, pls proceed to page 5**
* **Consent given by patient/caregiver *(Refer to patient consent form for deprescribing)*: Yes/No *(Circle the appropriate option)* If No, but wish to proceed with deprescribing, pls provide reason(s) for justification:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Tick and fill in blanks where appropriate***

\_\_Trial tapering; reduce dose:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Reduce dose:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Discontinue:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Switch drug (e.g. to H2RA, antacid):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Step 5: Monitor patient and provide support**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Time from PPI depres-cribing (Week #) | Return of symptoms (Yes/No) | Specify any return of symptoms | Action taken (e.g., increase/ decrease dose, restart med, start new drug) | Other adverse withdrawal reactions (please specify) |
| 1 |  |  |  |  |
| 2 |  |  |  |  |
| 6 |  |  |  |  |

**Laxatives**

**Steps 2, 3: Consider overall risk/appropriateness of drug and assess if drug can be discontinued based on the following: *(Tick where appropriate)***

\_\_Lack of indication; Symptoms have been resolved; Drug causing the symptoms has been ceased

\_\_Multiple drugs prescribed for same indication; Pls specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Adverse reactions from laxatives; Pls specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Lack of drug effectiveness for symptomatic relief

\_\_Preference of patient/caregiver (e.g., adherence issues); Pls specify:\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Step 4: Plan and initiate drug withdrawal**

* **Decision whether to deprescribe: Yes/No *(Circle the appropriate option)* If No, pls proceed to page 5**
* **Consent given by patient/caregiver *(Refer to patient consent form for deprescribing)*: Yes/No *(Circle the appropriate option)* If No, but wish to proceed with deprescribing, pls provide reason(s) for justification:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Tick and fill in blanks where appropriate***

\_\_Trial tapering; reduce dose:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Reduce dose:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Discontinue:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Switch drug:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Step 5: Monitor patient and provide support**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Time from laxative depres-cribing (Week #) | Return of symptoms (Yes/No) | Specify any return of symptoms | Action taken (e.g., increase/ decrease dose, restart med, start new drug) | Other adverse withdrawal reactions (please specify) |
| 1 |  |  |  |  |
| 2 |  |  |  |  |
| 6 |  |  |  |  |

**Analgesics: Paracetamol, NSAIDs, Weak opioids**

**Steps 2, 3: Consider overall risk/appropriateness of drug and assess if drug can be discontinued based on the following: *(Tick where appropriate)***

\_\_Lack of indication; Symptoms have been resolved

\_\_Multiple drugs prescribed for same indication; Pls specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Adverse reactions from NSAIDs/opioids; Pls specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Drug interaction/Contraindication; Pls specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Lack of drug effectiveness for symptomatic relief

\_\_Preference of patient/caregiver (e.g., adherence issues); Pls specify:\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Step 4: Plan and initiate drug withdrawal**

* **Decision whether to deprescribe: Yes/No *(Circle the appropriate option)* If No, pls proceed to page 5**
* **Consent given by patient/caregiver *(Refer to patient consent form for deprescribing)*: Yes/No *(Circle the appropriate option)* If No, but wish to proceed with deprescribing, pls provide reason(s) for justification:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Tick and fill in blanks where appropriate***

\_\_Trial tapering; reduce dose:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Reduce dose:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Discontinue:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Switch drug:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Step 5: Monitor patient and provide support**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Time from analgesicdepres-cribing (Week #) | Return of symptoms (Yes/No) | Specify any return of symptoms | Action taken (e.g., increase/ decrease dose, restart med, start new drug) | Other adverse withdrawal reactions (please specify) |
| 1 |  |  |  |  |
| 2 |  |  |  |  |
| 6 |  |  |  |  |

**Antiemetics**

**Steps 2, 3: Consider overall risk/appropriateness of drug and assess if drug can be discontinued based on the following: *(Tick where appropriate)***

\_\_Lack of indication; Symptoms have been resolved; Drug causing the symptoms has been ceased

\_\_Multiple drugs prescribed for same indication; Pls specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Adverse reactions from antiemetics; Pls specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Drug interaction/Contraindication; Pls specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Lack of drug effectiveness for symptomatic relief

\_\_Preference of patient/caregiver (e.g., adherence issues); Pls specify:\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Step 4: Plan and initiate drug withdrawal**

* **Decision whether to deprescribe: Yes/No *(Circle the appropriate option)* If No, pls proceed to page 5**
* **Consent given by patient/caregiver *(Refer to patient consent form for deprescribing)*: Yes/No *(Circle the appropriate option)* If No, but wish to proceed with deprescribing, pls provide reason(s) for justification:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Tick and fill in blanks where appropriate***

\_\_Trial tapering; reduce dose:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Reduce dose:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Discontinue:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Switch drug:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Step 5: Monitor patient and provide support**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Time from antieme-tics depres-cribing (Week #) | Return of symptoms (Yes/No) | Specify any return of symptoms | Action taken (e.g., increase/ decrease dose, restart med, start new drug) | Other adverse withdrawal reactions (please specify) |
| 1 |  |  |  |  |
| 2 |  |  |  |  |
| 6 |  |  |  |  |

**Time taken for deprescribing**

**DOCTOR:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHARMACIST (Med review):**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date before deprescribing intervention:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Constipation – BNO ≥ 2 days Yes/No *(Circle the appropriate option)*

**Discharge date or follow-up date after intervention:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Constipation – BNO ≥ 2 days Yes/No *(Circle the appropriate option)*