High Risk Medications for Regular Rx Review

Drug class	Common examples	Why considered high risk	Key review / monitoring requirements	Risk if review refused
Anticoagulants	Warfarin, apixaban, rivaroxaban, dabigatran	Major bleeding, intracranial haemorrhage, under-anticoagulation and thrombosis; renal accumulation with some agents	**Warfarin:** INR. **DOACs:** renal function, FBC, weight/age, bleeding, adherence, interacting medicines	🔴 **Very high** for unmonitored warfarin; high for DOACs where renal/clinical review is overdue
Narrow therapeutic index medicines	Lithium, digoxin	Small difference between therapeutic and toxic concentrations; renal impairment/interactions can rapidly increase toxicity	Drug-specific levels where indicated, renal function, electrolytes; lithium also TSH/calcium; clinical toxicity assessment	🔴 **Very high**, particularly lithium
Immunosuppressants / DMARDs	Methotrexate, azathioprine, ciclosporin, tacrolimus, leflunomide	Marrow suppression, hepatotoxicity, renal toxicity, infection; significant interactions	FBC, LFT, renal function; drug levels for selected agents; infection/adverse-effect review	🔴 **Very high** when required laboratory monitoring is absent
Antidiabetic medicines with significant hypoglycaemia risk	Insulin, gliclazide, other sulfonylureas	Severe hypoglycaemia, dosing errors; changing renal function, nutrition and frailty alter risk	HbA1c/glucose data, hypoglycaemia history, renal function, weight/nutrition, adherence and technique	🟠 **High**, particularly insulin, elderly/frail patients and renal impairment
Opioids	Morphine, oxycodone, fentanyl, methadone, tramadol	Respiratory depression, overdose, tolerance, dependence, interactions and diversion	Continuing indication, pain/function, dose, adverse effects, dependence/misuse, concurrent sedatives/alcohol	🔴 **Very high**, especially long-term/high-dose therapy
Sedatives / hypnotics	Benzodiazepines, zopiclone	Dependence, tolerance, falls, cognitive impairment, sedation and respiratory depression	Ongoing indication, duration, dose, falls/cognition, dependence, alcohol/opioid use and deprescribing opportunities	🟠 **High**, especially in older adults
Stimulants / controlled psychotropics	Methylphenidate, dexamfetamine	Cardiovascular effects, psychiatric adverse effects, misuse/diversion and controlled-drug considerations	BP, pulse, weight, therapeutic response, psychiatric status, adherence and diversion risk	🟠 **High**
Antipsychotics	Clozapine, olanzapine, quetiapine, risperidone, haloperidol	Metabolic disease, movement disorders, sedation, QT effects; clozapine has additional potentially fatal adverse effects	Weight/BMI, BP, HbA1c/glucose, lipids, movement symptoms; ECG when indicated. **Clozapine:** required haematological monitoring	🔴 **Very high for clozapine**; 🟠 high for many long-term antipsychotics
Antiepileptic / mood-stabilising medicines	Sodium valproate, carbamazepine, lamotrigine, levetiracetam	Seizure recurrence if stopped, toxicity/interactions; drug-specific hepatic, haematological and reproductive risks	Seizure control, adherence, adverse effects; drug-specific FBC/LFT/levels where indicated; reproductive risk where relevant	🟠 **High**, importantly because abrupt cessation may itself be dangerous
Cardiac antiarrhythmics	Amiodarone, sotalol, flecainide	Pro-arrhythmia, QT/conduction abnormalities and drug-specific systemic toxicity	ECG, electrolytes, renal/hepatic function as appropriate; amiodarone requires thyroid/liver and toxicity surveillance	🔴 **High–very high**
RAAS inhibitors	ACE inhibitors: cilazapril, enalapril. ARBs: losartan, candesartan	AKI, hyperkalaemia and hypotension, particularly with CKD/intercurrent illness	BP, creatinine/eGFR, potassium; repeat after initiation/dose changes and when clinically indicated	🟠 **Moderate–high**, depending on renal function/comorbidity

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Potassium-sparing diuretics / MRAs	Spironolactone, eplerenone	Potentially severe hyperkalaemia and renal deterioration	Potassium, creatinine/eGFR, BP; closer monitoring after initiation or dose changes	🔴 **High** if renal/electrolyte monitoring is substantially overdue
Other diuretics	Furosemide, bendroflumethiazide	Hyponatraemia, hypo/hyperkalaemia, dehydration, renal impairment and hypotension	Renal function, Na/K, BP, volume status and symptoms	🟠 **Moderate–high**, particularly elderly/frail patients
Chronic NSAIDs	Ibuprofen, naproxen, diclofenac, celecoxib	GI bleeding, AKI, hypertension, fluid retention and cardiovascular risk	Continuing indication, renal function, BP, GI risk and interacting medicines—especially anticoagulants/RAAS drugs	🟠 **Moderate–high**, particularly with CKD, older age or anticoagulation
Long-term systemic corticosteroids	Prednisone, dexamethasone	Diabetes, osteoporosis, infection, hypertension and adrenal suppression	Ongoing indication/dose, BP, glucose, weight, bone health, infection/adverse effects	🟠 **High**; prolonged therapy may also make abrupt cessation hazardous
Teratogenic / reproductive high-risk medicines	Valproate, methotrexate, isotretinoin and other drug-specific agents	Major fetal harm if pregnancy occurs; some also carry significant systemic toxicity	Pregnancy potential, contraception/pregnancy-prevention requirements where applicable, counselling and drug-specific monitoring	🔴 **Very high** when relevant safeguards cannot be established

Practical classification for a repeat-prescribing policy

Category	Examples	Approach when review/monitoring is refused
🔴 **Very high risk / monitoring integral to safe prescribing**	**Warfarin, lithium, methotrexate, clozapine, tacrolimus/ciclosporin**	Routine repeat without required monitoring is generally difficult to justify. Establish urgency, assess risk of interruption, consider only a clinically justified bridge and actively arrange alternatives/escalation.
🟠 **High risk / regular clinical review important**	**DOACs, insulin, opioids, benzodiazepines, antipsychotics, antiepileptics, antiarrhythmics, spironolactone, long-term steroids**	Individual risk assessment. Check whether essential monitoring is current and whether a short supply is safer than interruption. Set explicit review/monitoring requirements.
🟡 **Risk highly dependent on patient factors**	**ACEi/ARB, other diuretics, sulfonylureas, chronic NSAIDs**	Consider age, frailty, CKD, comorbidities, interacting medicines and duration since monitoring. A medicine that is relatively routine in one patient may be high-risk in another.

Key principle: the medication class alone should not determine the decision. The prescriber should consider **drug risk × patient vulnerability × time since monitoring × information currently available × consequences of abruptly withholding treatment**.