



INDIAN HEALTH SERVICE

National Pharmacy and Therapeutics Committee

Formulary Brief: Hospice Medications

-August 2026-



Background:

The Indian Health Service (IHS) National Pharmacy and Therapeutics Committee (NPTC) conducted its initial review of medications used to treat hospice patients. Medication(s) listed on the National Core Formulary (NCF) relevant to this review include acetaminophen, bisacodyl -or- senna (any product), buprenorphine, duloxetine, fluoxetine, ibuprofen, loperamide, lorazepam, meloxicam, naproxen, nortriptyline, omeprazole, ondansetron, polyethylene glycol, pantoprazole, sertraline, and venlafaxine. Following this clinical review and analysis, there were **no modifications** to the NCF.

In 2024, the leading cause of death in the United States was heart disease, followed by cancer, accidents, stroke, chronic lower respiratory diseases, Alzheimer's-related conditions, diabetes, nephritis/nephrotic syndrome/ nephrosis, and chronic liver disease/cirrhosis.¹ In 2022, 1.7 million Medicare patients died under hospice care, representing 49.1% of Medicare beneficiaries during that year.² Common symptoms that may cause distress in end-of-life patients include pain/distress, weakness/fatigue, shortness of breath, lack of mobility/independence, psychosocial disturbances, and gastrointestinal problems.³

When caring for hospice patients, the focus differs markedly from the standard approach to health management. In more traditional primary care settings, the objective is to "cure" or minimize the burden or long-term effect(s) of a disease state. In a hospice setting however, the focus is to relieve symptoms, reduce distress, support decision making, and coordinate care in alignment with patient values.⁴ In addition to symptom management, hospice care addresses emotional, practical, and existential concerns. There is an intentional multi-disciplinary approach taken that ensures these areas all receive attention for both patients and families.

Discussion:

For pain management, many hospice care guidelines refer to the [World Health Organization \(WHO\) Analgesic Ladder](#) as reference or framework for guidance.⁵ This stepwise approach recommends acetaminophen or a non-steroidal anti-inflammatory drug (NSAID) for minor pain, a weak opioid (e.g., hydrocodone, tramadol) for moderate pain, and a strong opioid (e.g., morphine, fentanyl) for severe pain. It is also important to consider the individual patient when managing pain as hepatic and renal impairment can affect the clearance of the selected medications. Dose reductions, increased intervals, and cautious titration of dose may be necessary to ensure safe use.⁶ A retrospective study in 2006 compared pain control in ~12,000 terminally ill patients prescribed sustained-release morphine, sustained-release oxycodone, and transdermal fentanyl. The study concluded that there was no significant difference in pain severity or constipation between the three groups.⁷ A 2020 meta-analysis conducted on adjuvant analgesic use in critically ill patients found that the use adjuvant agents (acetaminophen, gabapentin, NSAIDs, and others) showed a significant reduction in pain scores 24 hours post intervention (95% CI: -1.29 to -0.47; $p < 0.0001$) and reported a significant reduction in opioid consumption (95% CI: -31.81 to -19.97; $p < 0.00001$).⁸

For treatment of dyspnea, morphine is the pharmacologic agent recommended if treatment of underlying cause and non-pharmacologic treatments are unsuccessful. Morphine in this setting should be used with caution and the uncertainty of benefit vs. adverse events should be considered. A 2026 Cochrane Review concluded that there was low-quality evidence to support the use of oral opioids to relieve breathlessness in adults with advanced disease and terminal illness. The analysis showed a possible, but not statistically significant, benefit in change from baseline with morphine (95% CI: -0.40 to 0.19, $p = 0.47$) and a small benefit in post-treatment score (95% CI: -0.53 to -0.10, $p = 0.004$). Patient sample sizes were low (97 in baseline group, 169 in post-treatment group) and opioids other than morphine were examined but failed to show statistical significance.⁹

End-of-life secretions can be potentially distressing to patients and families. Typical pharmacologic treatment includes anti-muscarinic agents. A systematic review of atropine, glycopyrrolate, ipratropium and scopolamine showed success in reducing noisy respirations, concluding equivalence in terms of efficacy between glycopyrrolate and scopolamine. The study also noted that glycopyrrolate does not cross the blood-brain barrier and subsequently had lesser effect on cardiac rate and rhythm.¹⁰ Again, sample size for these studies were limited.

Deprescribing is an important component of hospice care. Careful analysis of prescribed medications is necessary to ensure that active medications continue to provide benefit and medications that fail to provide ongoing benefit or have

intolerable side effects should be considered for discontinuation. When medication deprescribing occurs, conversations are necessary with patients and families to ensure they understand this rationale and avoid any perception that providers are “giving up” on their care. This will need to be individualized to every patient.¹¹

A variety of symptoms may be encountered during hospice care that require availability of pharmacotherapy for management. There are several options on the NCF for treatment of mental health concerns and gastrointestinal symptoms. In addition, there are many non-pharmacologic therapies for common symptoms that may be considered. Pain control can be improved through use of relaxation, distraction, comfort therapy, and other techniques shown to raise pain threshold or decrease the perception of pain. Dyspnea can be treated with pharmacotherapy to decrease severity of the symptom or by decreasing the perception of the symptom (cool air on face) of breathlessness. Secretions can be reduced by limiting fluid intake and stopping intravenous fluids or enteral nutrition. These measures may not treat symptoms entirely on their own but can help with overall success in treating the symptom(s).

Findings:

Most studies of the current treatment of hospice patients have low patient sample size and are significantly limited by the ethical issues/concerns involved with studying end-of-life and potentially withholding standard of care. The symptoms associated with end-of-life care have a broad range and will be highly individualized to the patient and the disease state(s).

If you have any questions regarding this document, please contact the NPTC at IHSNPTC1@ihs.gov. For more information about the NPTC, please visit the [NPTC website](#).

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