METHOTREXATE SHARED CARE PROTOCOL

Oral tablets – prescribing & monitoring

Sub-cutaneous injection – monitoring only

This Shared Care Protocol is for patients initiated on Methotrexate under the Rheumatology Department. The consultant will have detailed the expected treatment regimen in the clinic letter. The first 3 months of prescribing and monitoring will be undertaken by the Rheumatology department. Updates of dosages and results will be completed by the specialist nurses and documented in the patient hand held record as well as sent to the GP practice for information.

As part of the Shared Care LES, it is expected that ALL patients will have a transfer of care at 3 months, unless there are exceptional circumstances (such as unstable results). We would be grateful if your practice would take over the responsibility for:

- Prescribing the **oral** methotrexate **as 2.5mg tablets** (not sub-cut)
- Performing the blood tests and monitoring the results (payment via LES)
- Completion of the NPSA booklet at each blood test

The prescribing of the sub-cutaneous methotrexate injections will remain with the Rheumatology department.

If patients fail to attend for their monitoring, we recommend contacting them to arrange one further monitoring appointment, but thereafter to stop prescribing their methotrexate until the monitoring requirements have been met.

The patient carries a hand held monitoring book, which has been kept up to date by the Rheumatology department and/or GP prescriber, and contains patient information. This and other documents are available to download from the NPSA website at www.npsa.nhs.uk/health/alerts

Important Information:

- Repeat prescriptions should be retained separately (i.e. highlighted as different to all other repeat prescriptions), so the GP prescriber can ensure monitoring has been undertaken prior to signing and issuing to patient
- The weekly dose on the prescription should state the quantity of methotrexate 2.5mg tablets per dose, and on which day they are to be taken
- Folic acid should also be prescribed at a dose of 5mg weekly, to prevent toxicity. Increased to more frequent dosing if side effects occur. (Day(s) to be stated on prescription – usually day prior to methotrexate)
- Alcohol intake should be limited to 12 units per week.
- Methotrexate is contraindicated in pregnancy and when breastfeeding and contraception is therefore advised in patients who are sexually active. Both men and women should be advised to stop Methotrexate at least 3 months before a planned pregnancy.
- **Trimethoprim / Co-trimoxazole should NEVER be co-prescribed with methotrexate** (risk of bone marrow suppression)
- Avoid exposure to chickenpox and shingles. If infection develops it should be treated aggressively with antiviral medication and Rheumatology dept can be contacted for advice
- Live vaccines should not be given

- Annual flu jab is recommended (to be given by GP practice)
- Side effects include: Oral Ulceration / Nausea / Diarrhoea / Alopecia – drug continuation depends on severity and patient wishes

Treatment is usually started at a dose of 10 - 15mg **WEEKLY** using 2.5mg tablets and increased to 20-30mg **WEEKLY** according to clinical response. If nausea or poor efficacy then sub-cutaneous use may be considered, **at which point prescribing will return to the consultant concerned.** Oral Methotrexate dose maybe split across 2 days if side effects occur (total dose not to exceed 30mg WEEKLY)

Monitoring schedule:
- FBC/ U&E / LFT / CRP every 2 weeks until on a stable dose for 6 weeks, then monthly for 3 months
- Then every 3 months unless dose changes
- If dose increase: additional FBC/U&E/LFT at 2, 4 and 6 weeks until on stable dose for 6 weeks then revert to previous schedule
- Results to be entered into hand held monitoring booklet

IF:

WCC	$<3.5 \times 10^9/l$
Neutrophils	$<1.8 \times 10^9/l$
Platelets	$<150 \times 10^9/l$
AST or ALT	> 100

OR: Severe sore throat /Oral Ulceration / Fever / Rash

Stop medication and contact Rheumatology service.

If sudden onset breathlessness and cough assess the patient for infection, stop the methotrexate and contact Rheumatology dept.

If CRP elevated (>25) and patient symptomatic, inform Rheumatology department. If CRP suddenly elevated without significant change to joint symptoms assess patient for infection. Occasionally patients run a persistently high CRP without joint symptoms – this will usually be flagged up in clinic letters

The methotrexate should be stopped if the patient has a significant infection requiring antibiotics (or chickenpox / shingles), and restart once infection treated.

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Title of originator/author:	Dr Rakesh Kumari, Dr Gillian Smith, Dr Fiona Fawthrop, Rheumatology RFT; Eloise Summerfield, Medicines Management Team RCCG
Title of responsible committee/individual:	Consultants Rheumatology RFT; Medicines Management Team RCCG (BNF 10 Prescribing Advisor)
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Target audience:	TRFT consultants & nurses Rotherham CCG GPs & nurses

Version	Date	Author	Status	Comment
Version 1	July 2012	Dr James Maxwell RFT Eloise Summerfield RCCG	Archived	First version onto a two page format
Version 2	July 2014	Dr Gillian Smith, Dr Fiona Fawthrop, RFT; Eloise Summerfield, RCCG	Archived	Review – minimal changes
Version 3	March 2016	Dr Gillian Smith, Dr Fiona Fawthrop, RFT; Eloise Summerfield, RCCG	Archived	Clearer instructions in regards the NPSA booklets
Version 4	Nov 2017	Dr Rakesh Kumari, Dr Gillian Smith, Dr Fiona Fawthrop, RFT; Eloise Summerfield, RCCG	Current version	Extra blood tests at start & dose change. First paragraph re-worded to reflect current practice. Acceptance letter removed as this is now implied under the Shared Care LES