Central Manchester University Hospitals NHS
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Greater Manchester Interface Prescribing Group Shared Care Template

Shared Care Guideline for **Oral Methotrexate for Rheumatological Conditions**		**Reference Number** **CMFT-SCG-006**
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Date approved by Commissioners: **January 2013**	**Review Date:** **January 2015**	

Please complete all sections

1. Licensed Indications	*Oral methotrexate is licensed to treat adults with rheumatoid arthritis and is also widely used to treat other inflammatory arthritides and connective tissue diseases.*	
2. Therapeutic use & background	*Methotrexate is an anti-metabolite cytotoxic drug which inhibits DNA synthesis and cellular replication. It belongs to the group of DMARDs alongside gold, penicillamine, hydroxychloroquine, azathioprine, leflunomide, and sulfasalazine.*	
3. Contraindications (please note this does not replace the SPC or BNF and should be read in conjunction with it).	*Contraindications- Pregnancy and breast feeding, suspected local or systemic infection, bone marrow failure with unexplained anaemia and cytopenia. Following administration to a man or woman, conception should be avoided by using an effective contraception method for at least 3 months after finished course..* *Cautions: significant renal impairment from any cause, hepatitis B or C, history of TB, lung fibrosis*	
4. Prescribing in pregnancy and lactation	*This drug should not be prescribed during pregnancy or while breastfeeding.*	
5. Dosage regimen for continuing care	Route of administration	*Oral*
	CSM warning with methotrexate that doses are weekly and attention should be paid to the strength of methotrexate tablets prescribed and the frequency of dosing. 2.5mg tablets are recommended in Greater Manchester however, patients should be made aware of other strengths and to question possible discrepancies.	
	Dose to be prescribed including units, frequency and duration of treatment. *Please prescribe: 7.5-25mg ONCE weekly according to hospital instructions (the initial dose may be 5-15mg once weekly, increasing by 2.5mg-5mg every 2-6 weeks until the disease is stabilized) Only prescribe 2.5mg tablets to avoid dosing errors.*	

	Is titration required	**Yes**	
	Titrate dosage up by *2.5mg-5mg* every 2-6 weeks according to response. Maintenance dosage up to a maximum licensed dose of *25mg / week*. Rarely the maximum dose can be *30mg/week*.		
	Adjunctive treatment regime *Folic acid 5mg ONCE weekly also given but may be given more frequently if necessary (usually 3 days after methotrexate). Folic acid reduces the toxic effects of methotrexate. Folic acid can be given any day as long as it is not on the same day as methotrexate. If nausea or GI effects persist despite folic acid then folinic acid 15mg ONCE weekly can be used as an alternative.*		
	Conditions requiring dose reduction *Lower doses should be considered for frail elderly patients and those with poor renal function. If maximum oral dose is not effective or causes intolerance consider subcutaneous route of administration before discontinuation of the drug with referral to the rheumatology team.*		
	Usual response time *6 weeks to 3 months*		
	Duration of treatment: *ongoing*		
	Treatment to be terminated by *healthcare professional in consultation with Rheumatology Team.*		
	NB. All dose adjustments will be the responsibility of the initiating specialist care unless directions have been specified in the medical letter to the GP.		
6.Drug Interactions ***For a comprehensive list consult the BNF or Summary of Product Characteristics***	The following drugs must not be prescribed without consultation with the specialist: *Co-trimoxazole or trimethoprim must be avoided in patients taking methotrexate (increased antifolate effect and increases risk of bone aplasia). Live vaccines (e.g. oral polio, oral typhoid, MMR, BCG, yellow fever) should be avoided in patients taking methotrexate. Avoid concomitant use of cytotoxics with clozapine as increased risk of agranulocytosis Avoid concomitant use with retinoids as increased risk of hepatotoxicty and increased plasma levels.*		
	The following drugs may be prescribed with caution: *Caution with phenytoin (antifolate effect of methotrexate increased) and probenecid (excretion of methotrexate reduced)* *NSAIDs reduce tubular excretion of methotrexate and thereby enhance toxicity. However, NSAIDs are not contraindicated.* *Excess alcohol should be avoided (or limit to max. 6 units per week*)		

7. Adverse drug reactions

For a comprehensive list (including rare and very rare adverse effects), or if significance of possible adverse event uncertain, consult Summary of Product Characteristics or BNF

Specialist to detail below the action to be taken upon occurrence of a particular adverse event as appropriate.

Adverse event System – symptom/sign	**Action to be taken** Include whether drug should be stopped prior to contacting secondary care specialist	**By whom**
WBC<3.5x10^9/L Neutrophils <2.0x10^9/L *Platelets <150x10^9/L*	*Withhold until discussion with Rheumatology team*	*GP*
MCV>105 fl	*Check B12, folate and TSH. If abnormal treat any underlying abnormality. If normal, discuss with Rheumatology Team.*	*GP*
AST/ALT rise > 2x upper limit of normal	*Withhold until discussion with Rheumatology team as risk of liver cirrhosis*	*GP*
Declining renal function i.e. creatinine increasing > 1.5 fold above baseline	*Withhold until discussion with Rheumatology team as risk of renal failure*	*GP*
New or increasing dyspnoea and/or dry cough	*Withhold and discuss urgently with rheumatology team as risk of interstitial pneumonitis*	*GP*
Severe sore throat, abnormal bruising	*Withhold and carry out urgent FBC as risk of bone marrow suppression*	*GP*
Suspected infection requiring antibiotics	*Withhold temporarily until infection cleared*	*GP*

The patient should be advised to report any of the following signs or symptoms to their GP without delay:

Severe skin rash that causes blistering,
Persistent cough, pain or difficulty breathing or become breathless
Skin rash and fever with swollen glands
Sore throat, fever, chills or achiness
Severe allergic reaction (anaphylactic reaction)

Other important co morbidities (e.g. chickenpox exposure). Include advice on management and prevention and who will be responsible for this in each case:

Pneumovax and annual 'flu vaccine should be given. Passive immunisation should be carried out using Varicella zoster immunoglobulin (VZIG) in non-immune patients if exposed to chickenpox or shingles.

	Any adverse reaction to a black triangle drug or serious reaction to an established drug should be reported to the MHRA via the "Yellow Card" scheme. *Myelosuppression, liver cirrhosis, pneumonitis*
8.Baseline investigations	*List of investigations / monitoring undertaken by secondary care* *Chest X-ray* *FBC* *U&E* *LFTs* *Pulmonary function tests (depending on clinical indication)*
9. Ongoing monitoring requirements to be undertaken by GP	**Is monitoring required?** — **Yes or No (if yes complete following section)** *Yes*

Monitoring	Frequency	Results	Action	By whom
FBC, U&E, LFT, (ESR desirable but not essential)	***During dose titration**: Every 2 weeks until 6 weeks after final dose increase.* ***Maintenance dose**: Every 4 weeks* . *Testing can be reduced to every 8 weeks after one year of stable results.*	*See Section 7: Adverse drug reactions above*		*GP*

10. Pharmaceutical aspects	*e.g. special storage requirements, washout periods Or where there are "no special considerations"* *Only supply 2.5mg tablets to avoid dosing errors as per NPSA alert and CSM warning.*
11. Secondary care contact information	**If stopping medication or needing advice please contact:** **To contact The Kellgren Centre Rheumatology Manchester Royal Infirmary:** **Enquiries regarding blood monitoring and results please contact the specialist nurses below:** **Specialist Nurse Jane Hawthorne 0161 276 4688** **Specialist Nurse Melissa Aris 0161 701 1454** **Specialist Nurse Carole Hill 0161 701 1454** **Fax number for GP blood results 0161 276 8690** **Consultant contact details below:** **Professor Ian Bruce 0161 276 4626** **Professor Ann Barton 0161 276 4626** **Dr Kimme Hyrich 0161 276 4627** **Dr Pauline Ho 0161 276 4397** **Dr Rachel Gorodkin 0161 276 4628** **To contact Rheumatology Department Trafford General Hospital:**

	Trafford Rheumatology helpline number 0161 746 2162 **Consultant contact details below:** **Dr Frank McKenna 0161 746 2395** **Dr Preeti Shah 0161 746 2395**
12. Criteria for shared care	Prescribing responsibility will only be transferred when ▪ Treatment is for a specified indication and duration. ▪ Treatment has been initiated and established by the secondary care specialist. ▪ The patient's initial reaction to and progress on the drug is satisfactory. ▪ The GP has no objection in each individual case that shared care is appropriate. ▪ The patient's general physical, mental and social circumstances are such that he/she would benefit from shared care arrangements
13. Responsibilities of initiating specialist	Initiate treatment and prescribe for the 1st 3 months of treatment. Undertake baseline monitoring. Advise GP of any dose adjustments. Monitor patient's initial reaction to and progress on the drug. Ensure that the patient has an adequate supply of medication until GP supply can be arranged. Continue to monitor and supervise the patient according to this protocol, while the patient remains on this drug, and agree to review the patient promptly if contacted by the GP. Provide GP with diagnosis, relevant clinical information and baseline results if problematic, treatment to date and treatment plan, duration of treatment before consultant review. Provide GP with details of outpatient consultations, ideally within 14 days of seeing the patient *or* inform GP if the patient repeatedly does not attend appointments. Provide GP with advice on when to stop this drug. Provide patient with relevant drug information to enable informed consent to therapy. Provide patient with relevant drug information to enable understanding of potential side effects and appropriate action Provide patient with relevant drug information to enable understanding of the role of monitoring. Provide patient with monitoring booklet. Provide patient with rheumatology nurse helpline contact number.
14. Responsibilities of the GP	--- Continue treatment as directed by the specialist. Ensure no drug interactions with concomitant medicines (see section 6.) To monitor and prescribe in collaboration with the specialist according to this protocol. To ensure that the monitoring and dosage record is kept up to date in the shared care booklet.

15. Responsibilities of the patient	To ensure blood monitoring is carried out once dose stable and responsibility transferred from secondary care. To inform Rheumatology Team if patient repeatedly does not attend routine blood monitoring. To undertake vaccination as directed by the initiating consultant, the BNF or Green Book. Symptoms or results are appropriately actioned, recorded and communicated to secondary care when necessary. --- To take medication as directed by the prescriber, or to contact the GP if not taking medication To attend hospital and GP clinic appointments, with monitoring booklet. Failure to attend will result in medication being stopped (on specialist advice). To report adverse effects to their rheumatologist or GP.
16. Supporting documentation	The SCG must be accompanied by a patient information leaflet. *Patient Information Leaflet EMC medicines Methotrexate* *Arthritis Research UK Patient Information Leaflet Methotrexate*
17. Patient monitoring booklet	The patient must receive a monitoring booklet from the specialist upon initiation of treatment. The patient must bring this booklet to all specialist and GP appointments where it will be updated by the health professional conducting the appointment. The patient must also produce the booklet to any health professional involved in other aspects of their care e.g. pharmacists and dentists.