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| Attach Label | logo_NHSGG&C_ 2_colour |
|  | **Rheumatology Unit****Hospital Address** |
| Date:  |

Dear Dr

**Methotrexate Injection for Self Administration**

Your patient has been receiving parenteral methotrexate which is included in the Near Patient Testing (NPT) specification. Following their last clinic appointment, I would be grateful if you could please:

1. **Prescribe Methotrexate** ......…**mg ONCE per WEEK** for patient self administration by subcutaneous injection as

**Metoject PEN® pre-filled auto injector (NHS GGC Preferred Formulation) /**

**Methofill® pre-filled injector / Nordimet® Pre-filled pen** (delete as appropriate).

Please note we no longer use the syringe. Please note it is important to maintain the same formulation.

* Day of the week **Methotrexate** to be injected………………………………………

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| ***FOR EXAMPLE****, as a number of choices exist on GP IT systems, to prescribe WEEKLY methotrexate by subcutaneous injection the following should be selected in the GP system (****example only - please refer above for dose to be prescribed****):* |
| **In EMIS** | **In Vision** |
| ***Metoject Pen Injection*** *select as appropriate* ***mg*** */ as appropriate* ***ml (50 mg/ml), pre-filled pen*** | ***Metoject PEN*** *select as appropriate* ***mg*** */ as appropriate* ***ml solution for injection pre-filled pen (medac UK)*** |

**2. DOSE recommendation**:

* No change, patient on target dose. [ ]
* Increase the dose to ……………mg/week after …………… weeks. [ ]
* If blood monitoring is satisfactory and patient tolerating treatment –

Further increase to ……………mg/week after …………… weeks. [ ]

*Please note that if the dose is changed, methotrexate injection (appropriate brand) of a different dosage will be required.*

*Please note that prescribing of trimethoprim or co-trimoxazole while on methotrexate should be avoided due to increased risk of haematological toxicity.*

1. **Prescribe FOLIC ACID**:
* ………mg ……… time(s) per week (omit on day of methotrexate)
* Day(s) of the week when folic acid to be taken………………………………………………………………

*Please note that the most common two options for folic acid are 5mg once a week or six days per week (avoiding the day of the methotrexate). However, other doses are at the discretion of the Rheumatologist.*

**4. Monitor FBCs/LFTs/U&Es** every   ………weeks until results are stable. *Ongoing monitoring should be carried out as per the NPT specification.*

For our part, Rheumatology will undertake to

* Train the patient to self-inject using the **appropriate Methotrexate pre-filled device**. Those unwilling/unable to self-inject will attend hospital weekly.
* Monitor the efficacy of the therapy.
* Provide Sharps boxes, which will be returned by the patient/carer direct to the hospital clinic.

Any queries please contact the Nurse Specialist on our helpline xxxxxxxxx or via our day ward on xxxxxxxx.

Thank you for your assistance.

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Block Caps \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Tel/Page No\_\_\_\_\_\_\_\_\_