

PRODUCT MONOGRAPH

10 mg (as methotrexate)

Antimetabolite and Antirheumatic

Pfizer Canada ULC
17300 Trans-Canada Highway
Kirkland, Québec
H9J 2M5

Date of Revision:
September 12, 2019

SUMMARY PRODUCT INFORMATION	3
INDICATIONS AND CLINICAL USE.....	3
CONTRAINDICATIONS	4
WARNINGS AND PRECAUTIONS.....	4
ADVERSE REACTIONS.....	12
DRUG INTERACTIONS	16
DOSAGE AND ADMINISTRATION	20
OVERDOSAGE	23
ACTION AND CLINICAL PHARMACOLOGY	24
STORAGE AND STABILITY.....	26
SPECIAL HANDLING INSTRUCTIONS	27
DOSAGE FORMS, COMPOSITION AND PACKAGING	28
PHARMACEUTICAL INFORMATION.....	29
CLINICAL TRIALS	30
DETAILED PHARMACOLOGY	31
TOXICOLOGY	33
REFERENCES	35

10 mg (as methotrexate)

Oral	Tablets:10 mg	Lactose monohydrate, Maize starch, Magnesium stearate, Polysorbate 80, Microcrystalline cellulose, and Starch pregelatinized (Prejel PA5)

Methotrexate Tablets, USP is indicated for Neoplastic diseases:

- Choriocarcinoma: Methotrexate — as single chemotherapy or in combination with other drugs.
- Acute Lymphoblastic Leukemia — as maintenance therapy.
- Head and Neck Cancer — in combination with other chemotherapies.
- Metastasis of unknown primary - as palliative combination chemotherapy.
- Burkitt's lymphoma.
- Advanced stages of childhood lymphoma (III and IV, St. Jude's Childrens' Research Hospital Staging System).
- Advanced cases of mycosis fungoides (cutaneous T-cell lymphoma).

Methotrexate Tablets, USP is indicated as a Disease Modifying Antirheumatic Drug (DMARD) in the following diseases where standard therapeutic interventions fail:

- Severe disabling psoriasis/psoriatic arthritis
- Severe disabling rheumatoid arthritis (RA)
- Severe disabling seronegative arthritides.

In the treatment of psoriasis, Methotrexate Tablets, USP should be restricted to severe recalcitrant, disabling psoriasis, which is not adequately responsive to other forms of therapy, but only when the diagnosis has been established after dermatologic consultation.

□ The clinical pharmacology of methotrexate has not been well studied in older individuals. Due to diminished hepatic and renal function, as well as decreased folate stores in this population, relatively low doses should be considered, and these patients should be closely monitored for early signs of toxicity.

□ Safety and effectiveness in pediatric patients have not been established, other than in cancer chemotherapy. Therefore, Methotrexate Tablets, USP should not be used as a DMARD in pediatric patients.

Methotrexate Tablets, USP is contraindicated:

- In patients who are hypersensitive to this drug or to any ingredient in the formulation or component of the container. For a complete listing, see section.
- In pregnant patients with psoriasis or rheumatoid arthritis and should be used in the treatment of neoplastic diseases only when the potential benefit outweighs the risk to the fetus.
- In women of childbearing potential until pregnancy is excluded.
- In nursing mothers.
- In patients with psoriasis or rheumatoid arthritis with alcoholism, alcoholic liver disease or other chronic liver disease.
- In patients with psoriasis or rheumatoid arthritis who have overt or laboratory evidence of immunodeficiency syndromes.
- In patients with psoriasis or rheumatoid arthritis who have pre-existing blood dyscrasias, such as bone marrow hypoplasia, leucopenia, thrombocytopenia or significant anemia.
- In patients with severe renal impairment including end stage renal disease with and without dialysis (see _____, _____, _____ and _____).
- With nitrous oxide anesthesia (see _____ and _____ : _____).

- Methotrexate Tablets, USP should be used only by physicians whose knowledge and experience includes the use of antimetabolite therapy because of the possibility of serious toxic reactions (see _____ : _____).
- Methotrexate has been reported to cause fetal death and/or congenital anomalies (see _____).

below). Therefore, use is contraindicated for women of childbearing potential until pregnancy is excluded and pregnant patients with psoriasis or rheumatoid arthritis (see section _____).

Fatal toxicities related to inadvertent daily rather than weekly dosing have been reported, particularly in elderly patients. It should be emphasized to the patient that the recommended dose is taken weekly for rheumatoid arthritis and psoriasis, and that daily use of the weekly recommended dose has led to fatal toxicity.

Because of the possibility of serious toxic reactions (which can be fatal), Methotrexate Tablets, USP should be used only in neoplastic diseases (as indicated), or in patients with severe, recalcitrant, disabling psoriasis or rheumatoid arthritis that are not adequately responsive to other forms of therapy. The patient should be informed by the physician of the risks involved and should be under a physician's constant supervision.

Toxic effects may be related in frequency and severity to dose or frequency of administration but have been seen at all doses. Because they can occur at any time during therapy, it is necessary to follow patients on Methotrexate Tablets, USP closely. Most adverse reactions are reversible if detected early. When such reactions do occur, the drug should be reduced in dosage or discontinued and appropriate corrective measures should be taken. If necessary, this could include the use of leucovorin calcium and/or acute, intermittent hemodialysis with a high-flux dialyzer (see _____). If Methotrexate Tablets, USP therapy is re-instituted, it should be carried out with caution, with adequate consideration of further need for the drug and with increased alertness as to possible recurrence of toxicity.

Methotrexate may induce "tumour lysis syndrome" in patients with rapidly growing tumours. Appropriate supportive and pharmacologic measures may prevent or alleviate this complication.

Methotrexate exits slowly from third space compartments (e.g., pleural effusions or ascites). This results in a prolonged terminal plasma half-life and unexpected toxicity. In patients with significant third space accumulations, it is advisable to evacuate the fluid before treatment and to monitor plasma methotrexate levels.

Unexpectedly severe (sometimes fatal) bone marrow suppression, aplastic anemia and gastrointestinal toxicity have been reported with concomitant administration of methotrexate (usually in high dosage) along with non-steroidal anti-inflammatory drugs (NSAIDs) (see _____).

Bone marrow and mucosal toxicity depend on dose and duration of exposure of high levels ($>2 \times 10^{-8}$ mol/L (0.02 micromolar)) of methotrexate. Since the critical time factor has been defined for these organs as being 42 hours in humans, this has the following implications:

- when drug levels exceeding 2×10^{-8} mol/L (0.02 micromolar) for >42 hours may forecast significant toxicity
- when toxicity can be minimized by appropriate administration of Leucovorin Calcium.

Methotrexate given concomitantly with radiotherapy may increase the risk of soft tissue necrosis and osteonecrosis.

Methotrexate Tablets, USP should be used with extreme caution in the presence of debility.

Malignant lymphomas may occur in patients receiving low-dose methotrexate. These lymphomas may regress following withdrawal of methotrexate without requiring treatment.

No controlled human data exist regarding the risk of neoplasia with methotrexate. Methotrexate has been evaluated in a number of animal studies for carcinogenic potential with inconclusive results. Although there is evidence that methotrexate causes chromosomal damage to animal somatic cells and human bone marrow cells, the clinical significance remains uncertain. Assessment of the carcinogenic potential of methotrexate is complicated by conflicting evidence of an increased risk of certain tumours in rheumatoid arthritis. Benefit should be weighed against this potential risk before using Methotrexate Tablets, USP alone or in combination with other drugs, especially in children or young adults. (See _____)

If vomiting, diarrhea, or stomatitis occurs, resulting in dehydration, Methotrexate Tablets, USP should be discontinued until recovery occurs. Diarrhea and ulcerative stomatitis require interruption of therapy; otherwise, hemorrhagic enteritis and death from intestinal perforation may occur. Methotrexate Tablets, USP should be used with extreme caution in the presence of peptic ulcer disease or ulcerative colitis.

Use caution when administering high-dose methotrexate to patients receiving proton pump inhibitor (PPI) therapy as concomitant use of some PPIs, such as omeprazole, esomeprazole, and pantoprazole, with methotrexate (primarily at high dose), may elevate and prolong serum levels of methotrexate and/or its metabolite hydromethotrexate, possibly leading to methotrexate toxicities (see _____ □)

Methotrexate Tablets, USP should be used with caution in patients with impaired bone marrow function and previous or concomitant wide field radiotherapy. Methotrexate may produce marked bone marrow depression with resultant anemia, aplastic anemia, pancytopenia, leucopenia, neutropenia, and/or thrombocytopenia. In controlled clinical trials in rheumatoid arthritis (n=128), leucopenia (WBC $<3000/\text{mm}^3$) was seen in 2 patients, thrombocytopenia (platelets $<100,000/\text{mm}^3$) in 6 patients, and pancytopenia in 2 patients.

In psoriasis and rheumatoid arthritis, Methotrexate Tablets, USP should be stopped immediately if there is a significant drop in blood counts. In the treatment of neoplastic diseases, Methotrexate Tablets, USP should be continued only if the potential benefit warrants the risk of severe myelosuppression. Patients with profound granulocytopenia and fever should be evaluated immediately and usually require parenteral broad-spectrum antibiotic therapy.

Methotrexate has the potential for acute (elevated transaminases) and chronic (fibrosis and cirrhosis) hepatotoxicity. Acutely, liver enzyme elevations are frequently seen after methotrexate administration and are usually not a reason for modification of methotrexate therapy. Liver enzyme elevations are usually transient and asymptomatic, and also do not appear predictive of subsequent hepatic disease. Persistent liver abnormalities, and/or decrease of serum albumin may be indicators of serious liver toxicity. Chronic toxicity is potentially fatal; it generally has occurred after prolonged use (generally two years or more) and after a total cumulative dose of at least 1.5 grams. Liver biopsy after sustained use often shows histologic changes, and fibrosis and cirrhosis have been reported; these latter lesions may not be preceded by symptoms or abnormal liver function tests in the psoriasis population. Periodic liver biopsies are usually recommended for psoriatic patients who are under long-term treatment. Persistent abnormalities in liver function tests may precede appearance of fibrosis or cirrhosis in the rheumatoid arthritis population. In studies in psoriatic patients, hepatotoxicity appeared to be a function of total cumulative dose and appeared to be enhanced by alcoholism, obesity, diabetes and advanced age. An accurate incidence rate has not been determined; the rate of progression and reversibility of lesions is not known. Special caution is indicated in the presence of pre-existing liver damage or impaired hepatic function.

Methotrexate has caused reactivation or worsening of hepatitis B and C infections, in some cases resulting in death. Some cases of hepatitis B reactivation have occurred after discontinuation of methotrexate. Prior to treatment with Methotrexate Tablets, USP, clinical and laboratory evaluation should be performed to evaluate preexisting hepatitis virus B and hepatitis virus C infection. Methotrexate Tablets, USP is not recommended for patients with active or chronic hepatitis B or C infection.

In psoriasis, liver damage and function tests, including serum albumin and prothrombin time, should be performed several times prior to dosing, but are often normal in the face of developing fibrosis or cirrhosis. These lesions may be detectable only by biopsy. The usual recommendation is to obtain a liver biopsy: 1) before the start of therapy or shortly after initiation of therapy (4-8 weeks); 2) after a total cumulative dose of 1.5 grams; and 3) after each additional 1.0 to 1.5 grams. Moderate fibrosis or any cirrhosis normally leads to discontinuation of the drug; mild fibrosis normally suggests a repeat biopsy in 6 months. Milder histologic findings such as fatty change and low-grade portal inflammation are relatively common pre-therapy. Although these mild changes are usually not a reason to avoid or discontinue Methotrexate Tablets, USP therapy, the drug should be used with caution.

Clinical experience with liver disease in rheumatoid arthritis is limited, but the same risk factors would be anticipated. Liver function tests are also usually not reliable predictors of histological changes in this population.

In rheumatoid arthritis, advanced age at first use of methotrexate, and increasing duration of therapy have been reported as risk factors for hepatotoxicity. Persistent abnormalities in liver function tests may precede appearance of fibrosis or cirrhosis in the rheumatoid population. Liver function tests should be performed at baseline and at 4-8 week intervals in patients receiving Methotrexate Tablets, USP for rheumatoid arthritis. Pretreatment liver biopsy should be performed for patients with a history of excessive alcohol consumption, persistently abnormal baseline liver function test values, or chronic hepatitis B or C infection. During therapy, liver biopsy should be performed if there are persistent liver function test abnormalities, or there is a decrease in serum albumin below the normal range (in the setting of well controlled rheumatoid arthritis).

If the results of a liver biopsy show mild changes (Roenigk grades I, II, IIIa), Methotrexate Tablets, USP may be continued and the patient monitored according to the recommendations listed above. Methotrexate Tablets, USP should be discontinued in any patient who displays persistently abnormal liver function tests and refuses liver biopsy, or in any patient whose liver biopsy shows moderate to severe changes (Roenigk grade IIIb or IV).

There is a combined reported experience in 217 rheumatoid arthritis patients with liver biopsies both before and during treatment (after a cumulative dose of at least 1500 mg) and in 714 patients with a biopsy only during treatment. There are 64 (7%) cases of fibrosis and 1 (0.1%) case of cirrhosis. Of the 64 cases of fibrosis, 60 were deemed mild. The reticulin stain is more sensitive for early fibrosis and its use may increase these figures. It is unknown whether even longer use will increase these risks.

Methotrexate Tablets, USP should be used with extreme caution in the presence of active infection, and is contraindicated in patients with overt or laboratory evidence of immunodeficiency syndromes (see _____).

Immunization may be ineffective when given during methotrexate therapy. Immunization with live virus vaccines is generally not recommended. Hypogammaglobulinemia has been reported rarely.

There have been reports of leukoencephalopathy following intravenous administration of methotrexate to patients who have had craniospinal irradiation. Serious neurotoxicity, frequently manifested as generalized or focal seizures, has been reported with unexpectedly increased frequency among pediatric patients with acute lymphoblastic leukemia who were treated with intravenous methotrexate (1 g/m²). Symptomatic patients were commonly noted to have leukoencephalopathy and/or microangiopathic calcifications on diagnostic imaging studies. Chronic leukoencephalopathy has also been reported in patients with osteosarcoma who received repeated doses of high-dose methotrexate with leucovorin rescue even without cranial

irradiation. There are also reports of leukoencephalopathy in patients who received low oral doses (4-8 mg/week) of methotrexate therapy for rheumatoid arthritis or psoriatic arthritis. Discontinuation of Methotrexate Tablets, USP does not always result in complete recovery.

A transient acute neurologic syndrome has been observed in patients treated with high dosage regimens. Manifestations of this neurologic disorder may include behavioural abnormalities, focal sensorimotor signs, including transient blindness and abnormal reflexes. The exact cause is unknown.

Cases of severe neurological adverse reactions that ranged from headache to paralysis, coma and stroke-like episodes have been reported mostly in juveniles and adolescents given methotrexate in combination with intravenous cytarabine.

Methotrexate is contraindicated in patients with severe renal impairment including end stage renal disease with and without dialysis (see _____ and _____, _____). Methotrexate therapy in patients with mild and moderate renal impairment should be undertaken with extreme caution, and at reduced dosages, because renal dysfunction will prolong methotrexate elimination. Methotrexate may cause renal damage that may lead to acute renal failure. High doses of methotrexate used in the treatment of osteosarcoma may cause renal damage leading to acute renal failure. Nephrotoxicity is due primarily to the precipitation of methotrexate and 7-hydroxymethotrexate in the renal tubules. Close attention to renal function including adequate hydration, urine alkalinization and measurement of serum methotrexate and creatinine levels are essential for safe administration.

Nephritis has been reported on co-administration with nitrous oxide anesthesia in rheumatoid arthritis patients (see _____ and _____ : _____).

Methotrexate-induced lung disease, including acute or chronic interstitial pneumonitis, is a potentially dangerous lesion which may occur at any time during therapy and which has been reported at low doses. It is not always fully reversible and fatalities have been reported. Cases of pleural effusion with or without interstitial pneumonitis have also been reported at any time during therapy at low doses. Pulmonary symptoms (especially a dry nonproductive cough) or a nonspecific pneumonitis occurring during methotrexate therapy may be indicative of a potentially dangerous lesion and require interruption of treatment and careful investigation. Although clinically variable, the typical patient with methotrexate-induced lung disease presents with fever, cough, dyspnea, hypoxemia, and an infiltrate on chest X-ray; infection (including pneumonia) needs to be excluded. This lesion can occur at all dosages.

Potentially fatal opportunistic infections, especially *Pneumocystis carinii* pneumonia, may occur with methotrexate therapy. When a patient presents with pulmonary symptoms, the possibility of *Pneumocystis carinii* should be considered.

Pulmonary alveolar haemorrhage has been reported with methotrexate. This event may also be associated with vasculitis and other comorbidities. Prompt investigations should be considered when pulmonary alveolar haemorrhage is suspected to confirm the diagnosis.

Methotrexate causes embryotoxicity, abortion, and fetal defects in humans. It has also been reported to cause impairment of fertility, oligospermia and menstrual dysfunction in humans, during and for a short period after cessation of therapy (see _____). The risk of effects on reproduction should be discussed with both male and female patients taking Methotrexate Tablets, USP. (See _____).

Severe, occasionally fatal, dermatologic reactions, including toxic epidermal necrolysis (Lyell's Syndrome), Stevens-Johnson syndrome, exfoliative dermatitis, skin necrosis, and erythema multiforme, have been reported in children and adults, within days of oral, intramuscular, or intravenous methotrexate administration. Reactions were noted after single or multiple, low, intermediate or high doses of methotrexate in patients with neoplastic diseases, rheumatoid arthritis or psoriasis. Recovery has been reported with discontinuation of therapy.

Lesions of psoriasis may be aggravated by concomitant exposure to ultraviolet radiation. Radiation dermatitis and sunburn may be "recalled" by the use of methotrexate.

Methotrexate Tablets, USP is contraindicated in pregnant patients with psoriasis or rheumatoid arthritis (see _____ and _____ : _____) and should be used in the treatment of neoplastic diseases only when the potential benefit outweighs the risk to the fetus. Methotrexate has been reported to cause impairment of fertility, oligospermia and menstrual dysfunction in humans, during and for a short period after cessation of therapy. Methotrexate can cause fetal death, embryotoxicity, abortion, or teratogenic effects when administered to a pregnant woman.

Methotrexate Tablets, USP is contraindicated in women of childbearing potential until pregnancy is excluded and should be fully counselled on the serious risk to the fetus should they become pregnant while undergoing treatment (see _____). Pregnancy should be avoided if either partner is receiving Methotrexate Tablets, USP. The optimal time interval between the cessation of methotrexate treatment of either partner and pregnancy has not been clearly established. Published literature recommendations for time intervals vary from 3 months to one year. The risk of effects on reproduction should be discussed with both male and female patients taking Methotrexate Tablets, USP.

Methotrexate Tablets, USP is contraindicated in nursing mothers because of the potential for serious adverse reactions from methotrexate in breast-fed infants.

□
Safety and effectiveness in pediatric patients have not been established, other than in cancer chemotherapy.

□
The clinical pharmacology of methotrexate has not been well studied in older individuals. Due to diminished hepatic and renal function, as well as decreased folate stores in this population, relatively low doses should be considered. Fatal toxicities related to inadvertent daily rather than weekly dosing have been reported, particularly in elderly patients. Elderly patients should be closely monitored for early signs of hepatic, bone marrow and renal toxicity.

Methotrexate Tablets, USP is contraindicated in patients with severe renal impairment (see and _____).

Patients undergoing Methotrexate Tablets, USP therapy should be informed of the early signs and symptoms of toxicity and closely monitored so that toxic effects are detected promptly. Serum methotrexate level monitoring can significantly reduce toxicity and mortality by allowing the adjustment of methotrexate dosing and the implementation of appropriate rescue measures. Patients subject to the following conditions are predisposed to developing elevated or prolonged methotrexate levels and benefit from routine monitoring of levels: e.g., pleural effusion, ascites, gastrointestinal tract obstruction, previous cisplatin therapy, dehydration, aciduria, and impaired renal function. Some patients may have delayed methotrexate clearance in the absence of these features. It is important that patients be identified within 48 hours since methotrexate toxicity may not be reversible if adequate leucovorin rescue is delayed for more than 42 to 48 hours. Monitoring of methotrexate concentrations should include determination of a methotrexate level at 24, 48, or 72 hours, and assessment of the rate of decline in methotrexate concentrations (to determine how long to continue leucovorin rescue).

Baseline assessment should include a complete blood count with differential and platelet counts, hepatic enzymes, renal function tests, and a chest X-ray. During initial or changing doses, or during periods of increased risk of elevated methotrexate blood levels (e.g., dehydration), more frequent monitoring may also be indicated.

- Patients should have their blood tests checked at least monthly.
- Liver biopsies prior to Methotrexate Tablets, USP therapy are not indicated routinely. Liver function tests should be determined prior to the initiation of therapy with Methotrexate Tablets, USP and they should be monitored every 1 to 2 months. A relationship between abnormal liver function tests and fibrosis or cirrhosis of the liver has not been established. Transient liver function test abnormalities are observed frequently after methotrexate administration and are usually not cause for modification of Methotrexate

Tablets, USP therapy. Persistent liver function test abnormalities just prior to dosing and/or depression of serum albumin may be indicators of serious liver toxicity and require evaluation.

- Renal function should be monitored every 1 to 2 months.
- Pulmonary function tests may be useful if methotrexate-induced lung disease (e.g., interstitial pneumonitis) is suspected, especially if baseline measurements are available.

In general, the incidence and severity of acute side effects are related to dose, frequency of administration, and the duration of the exposure to significant blood levels of methotrexate to the target organs. The most serious reactions are discussed under section. The most frequently reported adverse reactions include ulcerative stomatitis, leucopenia, nausea, and abdominal distress. Other frequently reported adverse effects are malaise, undue fatigue, chills and fever, dizziness and decreased resistance to infection. Ulcerations of the oral mucosa are usually the earliest signs of toxicity.

Blood and lymphatic system disorders:

Leucopenia, anemia, aplastic anemia, thrombopenia, pancytopenia, agranulocytosis, lymphadenopathy and lymphoproliferative disorders (including reversible), neutropenia and eosinophilia have also been observed

Cardiac disorders:

Pericarditis and pericardial effusion (damage to heart, rarely).

Eye disorders:

Conjunctivitis, blurred vision, serious visual changes of unknown etiology, and transient blindness/vision loss.

Gastrointestinal disorders:

Gingivitis, stomatitis, enteritis, anorexia, nausea, vomiting, diarrhea, hematemesis, melena, gastrointestinal ulceration and bleeding, pancreatitis, intestinal perforation, non-infectious peritonitis, glossitis.

General disorders and administration site conditions:	Anaphylactoid reactions, vasculitis, fever, conjunctivitis, infection, sepsis, nodulosis, hypogammaglobulinaemia, and sudden death.
Hepatobiliary disorders:	Hepatotoxicity, acute hepatitis, chronic fibrosis and cirrhosis, decrease in serum albumin, liver enzyme elevations, hepatic failure.
Infection:	Other reported infections included nocardiosis, histoplasmosis, cryptococcosis, and disseminated <i>H. simplex</i> , cytomegalovirus infection, including cytomegaloviral pneumonia.
Metabolism and nutrition disorders:	Diabetes mellitus.
Musculoskeletal, connective tissue and bone disorders:	Stress fractures, soft tissue necrosis, osteonecrosis, arthralgia, myalgia and osteoporosis.
Neoplasms benign, malignant and unspecified (including cysts and polyps):	Tumour lysis syndrome. Malignant lymphomas, which may regress following withdrawal of methotrexate, may occur in patients receiving low-dose methotrexate, and thus may not require cytotoxic treatment. Discontinue Methotrexate Tablets, USP first and, if the lymphoma does not regress, appropriate treatment should be instituted.
Nervous system:	Cerebrospinal fluid pressure increased, neurotoxicity, arachnoiditis, paresthesia, headache, dizziness, drowsiness, speech impediment including dysarthria and aphasia; hemiparesis, paresis and convulsions. Following low doses, there have been occasional reports of transient subtle cognitive dysfunction, mood alteration, or unusual cranial sensations, leukoencephalopathy, or encephalopathy.
Renal and urinary disorders:	Renal failure, severe nephropathy or renal failure, azotemia, dysuria, cystitis, hematuria, urogenital dysfunction. Proteinuria has also been observed.
Reproductive system	

and breast disorders: Defective oogenesis or spermatogenesis, transient oligospermia, menstrual dysfunction, vaginal discharge and gynecomastia; infertility, abortion, fetal defects, loss of libido/impotence.

Respiratory, thoracic and mediastinal disorders: Pneumonia, interstitial alveolitis/pneumonitis often associated with eosinophilia, pulmonary fibrosis, pulmonary alveolar haemorrhage, *Pneumocystis carinii* pneumonia, pleural effusion. Dyspnea, chest pain, hypoxia, respiratory fibrosis, pharyngitis, and chronic interstitial obstructive pulmonary disease and alveolitis have occasionally occurred.

Skin disorders: Erythema, pruritus, photosensitisation, petechiae, loss of hair, skin necrosis, exfoliative dermatitis, painful erosion of psoriatic plaques, herpes zoster, vasculitis, urticaria, pigmentary changes, acne, ecchymosis, Stevens-Johnson syndrome, toxic epidermal necrolysis (Lyell's syndrome), furunculosis and telangiectasia. Drug reaction with eosinophilia and systemic symptoms.

Vascular disorders: Hypotension and thromboembolic events (including arterial thrombosis, cerebral thrombosis, deep vein thrombosis, retinal vein thrombosis, thrombophlebitis, and pulmonary embolus), vasculitis.

- Alopecia (common)
- Diarrhea (common)
- Dizziness (common)
- Elevated liver enzymes (very common)
- Leucopenia (common)
- Nausea/vomiting (very common)
- Pancytopenia (common)
- Rash/pruritus/dermatitis (common)
- Stomatitis (common)
- Thrombocytopenia (common)

The adverse reaction rates reported are very similar to those in the rheumatoid arthritis studies. Rarely, painful psoriatic plaque erosions may appear.

See _____ section.

Because these reactions are reported voluntarily from a population of uncertain size, it is generally not possible to reliably estimate their frequency or establish a causal relationship to drug exposure.

The following adverse events have also been reported during post-marketing experience with methotrexate:

Infections and Infestations	Infections (including fatal sepsis); Pneumonia; <i>Pneumocystis carinii</i> pneumonia; Nocardiosis; Histoplasmosis; Cryptococcosis; Herpes zoster; <i>H. simplex</i> hepatitis; Disseminated <i>H. simplex</i> ; Cytomegalovirus infection (including cytomegaloviral pneumonia); Reactivation of hepatitis B infection; Worsening of hepatitis C infection
Blood and Lymphatic System Disorders	Agranulocytosis; Pancytopenia; Leukopenia; Neutropenia; Lymphadenopathy and lymphoproliferative disorders (including reversible); Eosinophilia; Anemia megaloblastic; Renal vein thrombosis; Lymphoma; Aplastic anemia; Hypogammaglobulinemia
Nervous System Disorders	CSF pressure increased; Neurotoxicity; Arachnoiditis; Paraplegia; Stupor; Ataxia; Dementia; Dizziness; Paresthesia
Respiratory, Thoracic and Mediastinal Disorders	Chronic interstitial pulmonary disease; Alveolitis; Dyspnea; Chest pain; Hypoxia; Cough; Plural effusion
Gastrointestinal Disorders	Intestinal perforation; Noninfectious peritonitis; Glossitis; Nausea; Pancreatitis
Hepatobiliary Disorders	Hepatic failure
Skin and Subcutaneous Tissue Disorders	Drug reaction with eosinophilia and systemic symptoms; Dermatitis; Petechiae
Musculoskeletal, Connective Tissue and Bone Disorders	Osteonecrosis
Renal and Urinary Disorders	Proteinuria
Pregnancy, Puerperium and Perinatal Conditions	Fetal death, Abortion
Reproductive System and Breast Disorders	Urogenital dysfunction
General Disorders and Administration Site Conditions	Pyrexia; Chills; Malaise; Fatigue; Anaphylactic reactions
Endocrine Disorders	Diabetes

Ophthalmologic Disorders	Transient blindness/vision loss

The use of nitrous oxide anesthesia with methotrexate is contraindicated (see _____ : _____ , _____ : _____) : _____ and _____

In adults, oral absorption appears to be dose dependent. The bioavailability of orally administered methotrexate is reduced by food, particularly milk products. Methotrexate competes with reduced folates for active transport across cell membranes by means of a single carrier-mediated active transport process. Impaired renal function, as well as concurrent use of drugs such as weak organic acids that undergo tubular secretion, can markedly increase methotrexate serum levels. Laboratory studies demonstrate that methotrexate may be displaced from plasma albumin by various compounds including sulfonamides, salicylates, tetracyclines, chloramphenicol and phenytoin.

□
NSAIDs should not be administered prior to or concomitantly with high doses of methotrexate. Concomitant administration of NSAIDs with high-dose methotrexate therapy has been reported to elevate and prolong serum methotrexate levels, resulting in deaths from severe hematologic (including bone marrow suppression and aplastic anemia) and gastrointestinal toxicity. These drugs have been reported to reduce the tubular secretion of methotrexate, in an animal model, and may enhance its toxicity by increasing methotrexate levels.

Caution should be used when NSAIDs and salicylates are administered concomitantly with lower doses of Methotrexate Tablets, USP. In treating rheumatoid arthritis with methotrexate, the possibility of increased toxicity with concomitant use of NSAIDs including salicylates has not been fully explored. Despite the potential interactions, studies of methotrexate in patients with rheumatoid arthritis have usually included concurrent use of constant dosage regimens of NSAIDs without apparent problems. It should be appreciated however, that the doses used in rheumatoid arthritis (7.5 to 15 mg/week) are somewhat lower than those used in psoriasis and that larger doses could lead to toxicity.

□

Combined use of methotrexate with gold, penicillamine, hydroxychloroquine, or sulfasalazine has not been studied and may increase the incidence of adverse effects.

Amiodarone administration to patients receiving methotrexate treatment for psoriasis has induced ulcerated skin lesions.

The administration of L-asparaginase has been reported to antagonize the effect of methotrexate.

Bone marrow suppression and decreased folate levels have been described in the concomitant administration of triamterene and methotrexate.

Methotrexate in combination with leflunomide may increase the risk of pancytopenia.

Methotrexate is partially bound to serum albumin, and toxicity may be increased because of displacement by other highly bound drugs, such as sulfonyleureas, aminobenzoic acid, salicylates, phenylbutazone, phenytoin, sulfonamides, some antibiotics such as penicillins, tetracycline, pristinamycin, probenecid, and chloramphenicol.

Renal tubular transport is also diminished by probenecid; use of Methotrexate Tablets, USP with this drug should be carefully monitored.

Use caution when administering high-dose methotrexate to patients receiving proton pump inhibitor (PPI) therapy. Concomitant use of PPIs and high-dose methotrexate should be avoided especially in patients with renal impairment. Case reports and published population pharmacokinetic studies suggest that concomitant use of some PPIs, such as omeprazole, esomeprazole, and pantoprazole, with methotrexate (primarily at high dose), may elevate and prolong serum levels of methotrexate and/or its metabolite hydromethotrexate, possibly leading to methotrexate toxicities. In two of these cases, delayed methotrexate elimination was observed when high-dose methotrexate was co-administered with PPIs, but was not observed when methotrexate was co-administered with ranitidine. However, no formal drug interaction studies of methotrexate with ranitidine have been conducted.

□

□

Although not documented, other nephrotoxic drugs such as aminoglycosides, Amphotericin B, and Cyclosporin could theoretically increase methotrexate toxicity by decreasing its elimination.

The use of nitrous oxide anesthesia potentiates the effect of methotrexate on folate metabolism, yielding increased toxicity such as severe, unpredictable myelosuppression, stomatitis, neurotoxicity (with intrathecal administration of methotrexate) and nephritis (see and _____). In case of accidental coadministration, this effect can be reduced by the use of leucovorin rescue.

Penicillins and sulfonamides may reduce the renal clearance of methotrexate; hematologic and gastrointestinal toxicity have been observed in combination with methotrexate. Use of Methotrexate Tablets, USP with penicillins should be carefully monitored.

Renal tubular transport is diminished by ciprofloxacin; use of Methotrexate Tablets, USP with this drug should be carefully monitored.

Oral antibiotics such as tetracycline, chloramphenicol, and nonabsorbable broad spectrum antibiotics, may decrease intestinal absorption of methotrexate or interfere with the enterohepatic circulation by inhibiting bowel flora and suppressing metabolism of the drug by bacteria. For example: Neomycin, Polymyxin B, Nystatin, and Vancomycin decrease methotrexate absorption, whereas Kanamycin increases methotrexate absorption.

Trimethoprim/sulfamethoxazole has been reported rarely to increase bone marrow suppression in patients receiving methotrexate, probably by decreased tubular secretion and/or an additive antifolate effect. Concurrent use of the anti-protozoal *pyrimethamine* may increase the toxic effects of methotrexate because of an additive antifolate effect.

Methotrexate may decrease the clearance of theophylline; theophylline levels should be monitored when used concurrently with Methotrexate Tablets, USP.

Methotrexate increases the plasma levels of mercaptopurine. Combination of Methotrexate Tablets, USP and mercaptopurine may therefore require dose adjustment.

Vitamin preparations containing folic acid or its derivatives may decrease responses to methotrexate. Preliminary animal and human studies have shown that small quantities of intravenously administered leucovorin enter the cerebrospinal fluid primarily as 5-methyltetrahydrofolate and, in humans, remain 1 to 3 orders of magnitude lower than the usual methotrexate concentrations following intrathecal administration.

In patients with rheumatoid arthritis, or psoriasis, folic acid or folinic acid may reduce methotrexate toxicities such as gastrointestinal symptoms, stomatitis, alopecia, and elevated liver enzymes.

Before taking a folate supplement, it is advisable to check B₁₂ levels, particularly in adults over the age of 50, since folate administration can mask symptoms of B₁₂ deficiency.

Folate deficiency states may increase methotrexate toxicity.

Methotrexate given concomitantly with radiotherapy may increase the risk of soft tissue necrosis and osteonecrosis.

The potential for increased hepatotoxicity when methotrexate is administered with other hepatotoxic agents has not been evaluated. However, hepatotoxicity has been reported in such cases. Therefore, patients receiving concomitant therapy with Methotrexate Tablets, USP and other potential hepatotoxic agents (e.g., leflunomide, azathioprine, sulfasalazine, retinoids) should be closely monitored for possible increased risk of hepatotoxicity.

Methotrexate given concomitantly with IV cytarabine may increase the risk of severe neurologic adverse events such as headache, paralysis, coma and stroke-like episodes (see _____).

Combined use of methotrexate with other cytotoxic agents has not been studied and may increase the incidence of adverse effects.

The bioavailability of orally administered methotrexate is reduced by food, particularly milk products.

The effects of herbal products on the pharmacokinetics of methotrexate have not been studied.

Interactions with laboratory tests have not been established.

Use of alcohol with Methotrexate Tablets, USP is contraindicated (see). The effects of smoking, on the pharmacokinetics of methotrexate have not been specifically studied.

Some of the effects (e.g., dizziness and fatigue) may have an influence on the ability to drive or operate machinery.

-
- Oral administration in tablet form is often preferred when low doses are being administered since absorption is rapid and effective serum levels are obtained.
 - Methotrexate Tablets, USP may only be administered by physicians experienced in the treatment of neoplasia. Typical dosages reported in the literature for the following malignancies are listed in the following section.
 - The patient should be fully informed of the risks involved and should be under constant supervision of the physician (see).
 - All dosage schedules should be continually tailored to the individual patient. An initial test dose may be given prior to the regular dosing schedule to detect any extreme sensitivity to adverse effects (see). Maximal myelosuppression usually occurs in seven to ten days.
 - Both the physician and pharmacist should emphasize to the patient that the recommended dose is taken weekly in rheumatoid arthritis and psoriasis, and that mistaken daily use of the recommended dose has led to fatal toxicity.

Methotrexate remains the standard of therapy for patients with recurrent or metastatic disease. It has been given in a wide variety of doses and schedules.

For palliation of patients with advanced, incurable disease and acceptable renal function, it is appropriate to begin oral methotrexate with weekly doses of 40-50 mg/m² or biweekly doses of 15 to 20 mg/m² and escalate the dose in weekly increments until either mild toxicity or therapeutic response is achieved.

Methotrexate is administered orally in doses of 15 to 30 mg daily for a 5-day course. Such courses are usually repeated for 3 to 5 times as required, with rest periods of one or more weeks interposed between courses, until any manifesting toxic symptoms subside. The effectiveness of

therapy is ordinarily evaluated by 24-hour quantitative analysis of urinary chorionic gonadotropin hormone (beta-HCG), which should return to normal or less than 50 IU/24 hr usually after the third or fourth course and usually be followed by a complete resolution of measurable lesions in 4 to 6 weeks. One to two courses of methotrexate after normalization of beta-HCG are usually recommended. Before each course of the drug, careful clinical assessment is essential. Cyclic combination therapy of methotrexate with other antitumour drugs has been reported as being useful.

Since hydatidiform mole may precede choriocarcinoma, prophylactic chemotherapy with methotrexate has been recommended.

Chorioadenoma destruens is considered to be an invasive form of hydatidiform mole. Methotrexate Tablets, USP is administered in these disease states in doses similar to those recommended for choriocarcinoma.

In Burkitt's tumour, Stages I-II, methotrexate has produced prolonged remissions in some cases. Recommended dosage is 10 to 25 mg/day orally for 4 to 8 days. In Stage III, methotrexate is commonly given concomitantly with other antitumour agents. Treatment in all stages usually consists of several courses of the drug interposed with 7 to 10 day rest periods. Lymphosarcomas in Stage III may respond to combined drug therapy with Methotrexate Tablets, USP given in doses of 0.625 to 2.5 mg/kg daily.

The treatment of choice for localized histologically aggressive lymphoma is primary combination chemotherapy with or without involved-field radiation therapy.

□

Therapy with methotrexate appears to produce clinical responses in up to 50% of patients treated, but chemotherapy is not curative. Dosage is usually 2.5 to 10 mg daily by mouth for several weeks or months. Dose levels of drug and adjustment of dose regimen by reduction or cessation of drug are guided by patient response and hematologic monitoring.

Acute lymphoblastic leukemia (ALL) in children and young adolescents is the most responsive to present day chemotherapy. In young adults and older patients, clinical remission is more difficult to obtain and early relapse is more common.

Methotrexate alone or in combination with steroids was used initially for induction of remission in ALL. More recently corticosteroid therapy, in combination with other antileukemic drugs or in cyclic combinations with methotrexate included, has appeared to produce rapid and effective remissions. When used for induction, methotrexate in doses of 3.3 mg/m² in combination with 60 mg/m² of prednisone, given daily, produced remissions in 50% of patients treated, usually within a period of 4 to 6 weeks. Methotrexate in combination with other agents appears to be the drug of choice for securing maintenance of drug-induced remissions. When remission is achieved and supportive care has produced general clinical improvement, maintenance therapy is initiated, as follows: methotrexate is administered twice weekly by mouth in total weekly doses of 30 mg/m². If and when relapse does occur, re-induction of remission can again usually be obtained by repeating the initial induction regimen.

A variety of combination chemotherapy regimens have been used for both induction and maintenance therapy in ALL.

Recommended starting dose schedules:

- Weekly single oral dose schedule: 10 to 25 mg per week until adequate response is achieved.
- Divided oral dose schedule: 2.5 mg to 5.0 mg at 12-hour intervals for 3 doses, repeated weekly.

Dosages in each schedule may be gradually adjusted to achieve optimal clinical response; 25 mg/week should not ordinarily be exceeded.

Once optimal clinical response has been achieved, the dosage schedule should be reduced to the lowest possible effective dose and to the longest possible rest period.

Recommended starting dose schedules:

- Single oral doses of 7.5 mg once weekly.
- Divided oral dosages of 2.5 mg at 12-hour intervals for 3 doses given as a course once weekly.

Dosages in each schedule may be gradually adjusted to achieve optimal clinical response, but not ordinarily to exceed a total weekly dose of 20 mg.

Therapeutic response usually begins within 3 to 6 weeks and the patient may continue to improve for another 12 weeks or more. Upon achieving the therapeutically desired result, dosage should be reduced gradually to the lowest possible effective maintenance dose. The optimal duration of therapy is unknown; limited data from long-term studies indicate that the initial clinical improvement is maintained for at least 2 years with continued therapy.

□

Creatinine Clearance (mL/min)	% Standard Dose to Administer
>80	Full Dose
80	75
60	63

50	56
<50	Use alternative therapy

□

Safety and effectiveness in pediatric patients have not been established, other than in cancer chemotherapy (see _____ : _____, _____).

□

Due to diminished hepatic and renal function as well as decreased folate stores in elderly population, relatively low doses (especially in rheumatoid arthritis and psoriasis indications) should be considered and these patients should be closely monitored for early signs of toxicity. See _____ for reduced doses in oncology patients with renal impairment.

If a scheduled dose is missed, contact your doctor for instructions.

Overdose with methotrexate has occurred with oral administration.

Reports of oral overdose indicate accidental daily administration instead of weekly. Symptoms commonly reported include those symptoms and signs reported at pharmacologic doses, particularly hematologic and gastrointestinal reactions (for example, leukopenia, thrombocytopenia, anemia, pancytopenia, bone marrow suppression, mucositis, stomatitis, oral ulceration, nausea, vomiting, gastrointestinal ulceration, gastrointestinal bleeding). There have been reports of death following chronic overdose in the self-administered dosage for rheumatoid arthritis and psoriasis. In these cases, events such as sepsis or septic shock, renal failure, and aplastic anemia were also reported.

Discontinue or reduce dosage at the first sign of ulceration or bleeding, diarrhea, or marked depression of the hematopoietic system. Leucovorin is indicated to diminish the toxicity and counteract the effect of overdosages of methotrexate. Leucovorin administration should begin as promptly as possible. As the time interval between methotrexate administration and leucovorin initiation increases, the effectiveness of leucovorin in counteracting toxicity decreases. Monitoring of the serum methotrexate concentration is essential in determining the optimal dose and duration of treatment with leucovorin.

In cases of massive overdosage, hydration and urinary alkalinization may be necessary to prevent the precipitation of methotrexate and/or its metabolites in the renal tubules. Generally, neither standard hemodialysis nor peritoneal dialysis has been shown to improve methotrexate elimination. However, effective clearance of methotrexate has been reported with acute, intermittent hemodialysis using a high-flux dialyzer.

There are published case reports of intravenous carboxypeptidase G2 treatment to hasten clearance of methotrexate in cases of overdoses.

For management of a suspected drug overdose, contact your regional Poison Control Centre immediately.

Methotrexate is a folate antagonist.

Methotrexate inhibits dihydrofolate reductase (DHFR), the enzyme that reduces folic acid to tetrahydrofolic acid. Tetrahydrofolate must be regenerated via the DHFR-catalyzed reaction in order to maintain the intracellular pool of tetrahydrofolate one-carbon derivatives for both thymidylate and purine nucleotide biosynthesis. The inhibition of DHFR by folate antagonists (methotrexate) results in a deficiency in the cellular pools of thymidylate and purines and thus in a decrease in nucleic acid synthesis. Therefore, methotrexate interferes with DNA synthesis, repair, and cellular replication.

Methotrexate is most active against rapidly multiplying cells, because its cytotoxic effects occur primarily during the S phase of the cell cycle. Since cellular proliferation in malignant tissues is greater than in most normal tissues, methotrexate may impair malignant growth without irreversible damage to normal tissues. As a result, actively proliferating tissues such as malignant cells, bone marrow, fetal cells, buccal and intestinal mucosa, and cells of the urinary bladder are in general more sensitive to DHFR inhibition effects of methotrexate.

The cytotoxicity of methotrexate results from three important actions: inhibition of DHFR, inhibition of thymidylate synthase, and alteration of the transport of reduced folates. The affinity of DHFR to methotrexate is far greater than its affinity for folic acid or dihydrofolic acid, therefore, large doses of folic acid given simultaneously will not reverse the effects of methotrexate. However, Leucovorin calcium, a derivative of tetrahydrofolic acid may block the effects of methotrexate if given shortly after the antineoplastic agent.

Methotrexate has immunosuppressive activity. This may be a result of inhibition of lymphocyte multiplication. The mechanisms of action in the management of rheumatoid arthritis of the drug are not known, although suggested mechanisms have included immunosuppressive and/or anti-inflammatory effects.

In psoriasis, the rate of production of epithelial cells in the skin is greatly increased over normal skin. This differential in proliferation rates is the basis for the use of methotrexate to control the psoriatic process.

Orally administered methotrexate is absorbed rapidly in most, but not all patients and reaches peak serum levels in 1 to 2 hours in adults and 0.67 to 4 hours in children. Methotrexate is generally completely absorbed following parenteral administration, and after intramuscular injection peak serum concentrations occur in 30 to 60 minutes.

Methotrexate is widely distributed into body tissues with highest concentrations in the kidneys, gallbladder, spleen, liver and skin. Methotrexate in serum is approximately 50% protein-bound. After intravenous administration, the initial volume of distribution is approximately 0.18 L/kg (18% of body weight) and steady-state volume of distribution is approximately 0.4 to 0.8L/kg (40% to 80% of body weight). Methotrexate does not penetrate the blood-cerebrospinal fluid barrier in therapeutic amounts when given orally or parenterally.

At low doses, methotrexate does not appear to undergo significant metabolism; following high-dose therapy, methotrexate undergoes hepatic and intracellular metabolism to polyglutamated forms that can be converted back to methotrexate by hydrolase enzymes.

These polyglutamates act as inhibitors of dihydrofolate reductase and thymidylate syntheses. Small amounts of methotrexate polyglutamates may remain in tissues for extended periods. The retention and prolonged drug action of these active metabolites vary among different cells, tissues and tumours. A small amount of metabolism to 7-hydroxymethotrexate may occur at doses commonly prescribed. The aqueous solubility of 7-hydroxymethotrexate is 3 to 5 fold lower than the parent compound. Methotrexate is partially metabolized by intestinal flora after oral administration.

Renal excretion is the primary route of elimination and is dependent upon dosage and route of administration. Total clearance averages 12 L/h, but there is wide interindividual variation.

Excretion of single daily doses occurs through the kidneys in amounts from 80% to 90% within 24 hours. Repeated daily doses result in more sustained serum levels and some retention of methotrexate over each 24-hour period, which may result in accumulation of the drug within the tissues. The liver cells appear to retain certain amounts of the drug for prolonged periods even after a single therapeutic dose. Methotrexate is retained in the presence of impaired renal function and may increase rapidly in the serum and in the tissue cells under such conditions. Methotrexate does not penetrate the blood-cerebrospinal fluid barrier in therapeutic amounts when given orally or parenterally.

The terminal half-life reported for methotrexate is approximately 3 to 10 hours for patients receiving treatment for psoriasis, or rheumatoid arthritis or low dose antineoplastic therapy (less than 30 mg/m²).

Methotrexate clearance rates vary widely and are generally decreased at higher doses.

Methotrexate has been detected in human breast milk and is contraindicated during breast-feeding. The highest breast milk to plasma concentration ratio reached was 0.08:1.

In leukemic pediatric patients, oral absorption of methotrexate also appears to be dose-dependent and has been reported to vary widely (23% to 95%). A twenty-fold difference between highest and lowest peak levels (C_{\max} : 0.11 to 2.3 micromolar after a 20 mg/m² dose) has been reported. Significant interindividual variability has also been noted in time-to-peak concentration (T_{\max} 0.67 to 4 hours after a 15 mg/m² dose) and fraction of dose absorbed. The absorption of doses greater than 40 mg/m² has been reported to be significantly less than that of lower doses. In pediatric patients receiving methotrexate for acute lymphocytic leukemia (6.3 to 30 mg/m²), the terminal half-life has been reported to range from 0.7 to 5.8 hours.

The clinical pharmacology of methotrexate has not been well studied in older individuals. Due to diminished hepatic and renal function as well as decreased folate stores in this population, relatively low doses (especially in RA and psoriasis indications) should be considered and these patients should be closely monitored for early signs of toxicity.

Since the renal excretion of methotrexate is the primary route of elimination with 80% to 90% of the single daily doses of methotrexate excreted through the kidneys within 24 hours, methotrexate is retained in the presence of impaired renal function and may increase rapidly in the serum and in the tissue cells under such conditions, thus in patients with renal impairment the health care provider may need to adjust the dose to prevent accumulation of drug.

Hepatic excretion of methotrexate is a minor route of elimination. However, the liver cells appear to retain certain amounts of the drug for prolonged periods even after a single therapeutic dose. Special caution is indicated in the presence of pre-existing liver damage or impaired hepatic function.

Keep in a safe place out of the sight and reach of children.

Store Methotrexate Tablets, USP (10 mg) between 15°C and 25°C. Keep the tablet container in the outer carton in order to protect from light.

1. Methotrexate has no vesicant properties and does not show acute toxicity on topical contact with the skin or mucous membranes. However, persons involved with handling cytotoxic drugs should avoid contact with skin and inhalation of airborne particles.
2. Personnel regularly involved in the preparation and handling of antineoplastics should have bi-annual blood examinations.

1. Avoid contact with skin and inhalation of airborne particles by use of PVC gloves and disposable gowns and masks.
2. Place container and tablets in a plastic bag, seal and mark as hazardous waste. Incinerate at 1000°C or higher.

Dissolve tablets in a suitable quantity of normal sodium hydroxide (40 g per liter of water*) and discard in the sewer system with running water.

* Use appropriate safety equipment such as goggles and gloves while working with sodium hydroxide, since it can cause severe burns.

Non-disposable equipment that has come in contact with Methotrexate Tablets, USP may be rinsed with water and washed thoroughly with soap and water.

Wear gloves, mask, protective clothing. Place spilled material in an appropriate container (i.e. cardboard for broken glass) and then in a polyethylene bag; absorb remains with gauze pads or towels; wash area with water and absorb with gauze or towels again and place in bag; seal, double bag and mark as a hazardous waste. Dispose of waste by incineration or by other methods approved for hazardous materials. Personnel involved in cleanup should wash with soap and water.

Methotrexate Tablets, USP (10 mg) are available in bottles of 100.

Each capsule-shaped, yellow, scored tablet, engraved "M 10" contains 10 mg Methotrexate, Ph.Eur as the single active ingredient. There are no preservatives or colouring agents.

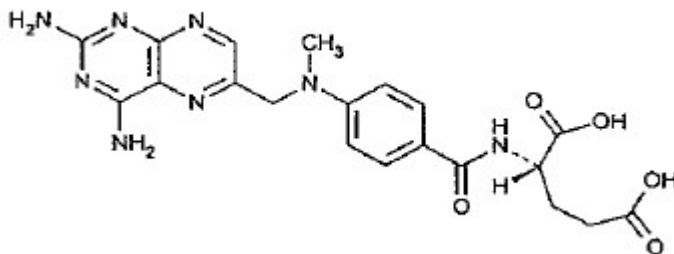
Maize Starch, lactose monohydrate, magnesium stearate, polysorbate 80, microcrystalline cellulose and starch pregelatinized (Prejel PA 5).

Proper name: Methotrexate

Chemical name: N-[4-[[[(2,4-diamino-6-pteridiny) methylamino] benzoyl]-L-glutamic acid

Molecular formula and molecular mass: C₂₀H₂₂N₈O₅ (454.45 g/mol)

Structural formula:



Physicochemical properties:

Physical Form: A yellow to orange crystalline powder. Contains not more than 12% water.

Solubility: Practically insoluble in water, chloroform, ether and alcohol, but freely soluble in dilute solutions of mineral acids, alkali hydroxides and carbonates.

	Controlled double-blind multicentre	Oral 18 weeks	n=189	N/A	N/A

One hundred eighty-nine patients with rheumatoid arthritis were entered into a prospective, controlled, double-blind multicentre trial comparing placebo and methotrexate (Williams et al, 1985).

One hundred ten patients completed 18 weeks of therapy. Virtually all of these patients were on concomitant non-steroidal anti-inflammatory medication and some were also taking low dosages of corticosteroids.

Patients received either 2.5 mg tablets of methotrexate or identical placebo tablets. Therapy was initiated at 1 tablet 3 times per week, with doubling of dosage permitted after 6 weeks if judged to be in the patient's interests.

Although no remissions were seen, patients able to tolerate low-dose pulse methotrexate therapy were significantly improved, compared with patients receiving placebo therapy, for all clinical variables measured, including joint pain/tenderness and swelling counts, rheumatoid nodules, and patient and physician assessment of disease activity.

□

Remission Improvement	0	0
Pain/tenderness*	10 (11%)	30 (32%)
Swelling*	4 (4%)	20 (21%)
Patient assessment*	7 (7%)	10 (11%)
Physician assessment**	3 (3%)	9 (10%)

* N = 94 methotrexate, 89 placebo

** N = 95 methotrexate, 94 placebo

A comparative bioequivalence study of Wyeth* Methotrexate and Pfizer Methotrexate 2.5 mg in cancer patients demonstrated that the two products were bioequivalent () based on the mean area under the time plasma concentration curve (AUC), time to reach peak concentration (T_{max}) and peak plasma valued (C_{max}).

□

AUC _T ** (units)	530.2 ng·hrs/mL	539.8 ng·hrs/mL
C _{MAX} *** (units)	156.6 ng/mL	179.7 ng/mL
T _{MAX} **** (h)	0.75 hrs	0.94 hrs

* The registered owner of the innovator has since been changed from Wyeth to Pharmascience.
 **AUC_T = Area under the plasma concentration – time curve
 ***C_{max} = Maximum plasma or blood concentration
 ****T_{max} = Time of maximum concentration

Orally administered methotrexate is absorbed rapidly in most, but not all patients and reaches peak serum levels in 1 to 2 hours in adults. Oral absorption appears to be dose-dependent. At doses of 30 mg/m² or less, methotrexate is generally well absorbed with a mean bioavailability of about 60%. The absorption of doses greater than 80 mg/m² is significantly less, possibly due to a saturation effect.

In leukemic pediatric patients, oral absorption has been reported to vary widely (23% to 95%). A twenty fold difference between highest and lowest peak levels (C_{max}: 0.11 to 2.3 micromolar after a 20 mg/m² dose) has been reported. Significant interindividual variability has also been noted in time to peak concentration (T_{max}: 0.67 to 4 hrs after a 15 mg/m² dose) and fraction of dose absorbed. The bioavailability of orally administered methotrexate is reduced by food, particularly milk products. The absorption of doses greater than 40 mg/m² has been reported to be significantly less than that of lower doses. Methotrexate is generally completely absorbed

from parenteral routes of injection. After intramuscular injection, peak serum concentrations occur in 30 to 60 minutes.

After intravenous administration, the initial volume of distribution is approximately 0.18 L/kg (18% of body weight) and steady-state volume of distribution is approximately 0.4 to 0.8 L/kg (40% to 80% of body weight). Methotrexate competes with reduced folates for active transport across cell membranes by means of a single carrier-mediated active transport process. At serum concentrations greater than 100 micromolar, passive diffusion becomes a major pathway by which effective intracellular concentrations can be achieved. Methotrexate in serum is approximately 50% protein-bound. Laboratory studies demonstrate that it may be displaced from plasma albumin by various compounds including sulfonamides, salicylates, tetracyclines, chloramphenicol, and phenytoin.

Methotrexate does not penetrate the blood-cerebrospinal fluid barrier in therapeutic amounts when given orally or parenterally. High cerebrospinal fluid concentrations of the drug may be attained by intrathecal administration.

In dogs, synovial fluid concentrations after oral dosing were higher in inflamed than uninflamed joints. Although salicylates did not interfere with this penetration, prior prednisone treatment reduced penetration into inflamed joints to the level of normal joints.

After absorption, methotrexate undergoes hepatic and intracellular metabolism to polyglutamated forms which can be converted back to methotrexate by hydrolase enzymes. These polyglutamates act as inhibitors of dihydrofolate reductase and thymidylate syntheses. Small amounts of methotrexate polyglutamates may remain in tissues for extended periods. The retention and prolonged drug action of these active metabolites vary among different cells, tissues and tumours. A small amount of metabolism to 7-hydroxymethotrexate may occur at doses commonly prescribed. Accumulation of this metabolite may become significant at the high doses used in osteogenic sarcoma. The aqueous solubility of 7-hydroxymethotrexate is 3 to 5 fold lower than the parent compound. Methotrexate is partially metabolized by intestinal flora after oral administration.

The terminal half-life reported for methotrexate is approximately three to ten hours for patients receiving treatment for psoriasis, rheumatoid arthritis or low-dose antineoplastic therapy (less than 30 mg/m²). For patients receiving high doses of methotrexate, the terminal half-life is eight to fifteen hours.

Renal excretion is the primary route of elimination and is dependent upon dosage and route of administration. With IV administration, 80% to 90% of the administered dose is excreted unchanged in the urine within 24 hours. There is limited biliary excretion amounting to 10% or less of the administered dose. Enterohepatic recirculation of methotrexate has been proposed.

Renal excretion occurs by glomerular filtration and active tubular secretion. Non-linear elimination due to saturation of renal tubular reabsorption has been observed in psoriatic patients at doses between 7.5 and 30 mg. Impaired renal function, as well as concurrent use of drugs such as weak organic acids that also undergo tubular secretion, can markedly increase methotrexate serum levels. Excellent correlation has been reported between methotrexate clearance and endogenous creatinine clearance.

Methotrexate clearance rates vary widely and are generally decreased at higher doses. Delayed drug clearance has been identified as one of the major factors responsible for methotrexate toxicity. It has been postulated that the toxicity of methotrexate for normal tissues is more dependent upon the duration of exposure to the drug rather than the peak level achieved. When a patient has delayed drug elimination due to compromised renal function, a third space effusion, or other causes, methotrexate serum concentrations may remain elevated for prolonged periods.

The potential for toxicity from high-dose regimens or delayed excretion is reduced by the administration of leucovorin calcium during the final phase of methotrexate plasma elimination. Pharmacokinetic monitoring of methotrexate serum concentrations may help identify those patients at high risk for methotrexate toxicity and aid in proper adjustment of leucovorin dosing.

The acute toxicity (LD₅₀) of methotrexate in mice ranges from 65 to 70 mg/kg intravenously. In dogs, the intravenous dose of 50 mg/kg was lethal. The main targets after a single dose were the hemolymphopoietic system and gastrointestinal (GI) tract.

The acute oral toxicity (LD₅₀) in rats was 180 mg/kg; subcutaneously, it is 58 mg/kg. The tolerance to methotrexate in mice increased with age. The toxic effects after repeated administration of methotrexate were investigated in mice and rats. The main targets of methotrexate in the above animal species were the hemolymphopoietic system, GI tract, lung, liver, kidney, testes, and skin. The tolerance of mice to chronic methotrexate doses increased with age.

In a 22-month carcinogenicity study in rats that received methotrexate at doses of 0.1, 0.2 and 0.4 mg/kg/day, 5 days/week every other week, little or no effect of the drug was observed. It has been concluded that methotrexate is apparently remarkably free from toxic effects when otherwise lethal doses are administered utilizing an intermittent dosage schedule providing for a recovery period of 9 days. For example, daily oral doses of 0.4 mg/kg are lethal doses both in dogs and rats when administered for up to two weeks; when 0.5 mg/kg and 0.4 mg/kg doses, respectively, were administered daily five times a week every other week for three months to dogs and ten months to rats, they were found to be essentially without toxicity.

Methotrexate is often used clinically in doses that are nearly toxic and may cause severe depression of all blood cellular elements. Constant supervision is recommended and signs of gastrointestinal ulceration and bleeding, including bleeding from the mouth, bone marrow

depression, primarily of the white cell series and alopecia are indications of toxicity. In general, toxicity is in direct proportion to dose and exposure time to methotrexate.

Toxicity of methotrexate to the bone marrow and gastrointestinal epithelium is not so much dependent on dosage as on the duration of exposure of these organs to the drug and its extracellular (plasma) concentration. For bone marrow and gastrointestinal tract, the critical time factor has been defined as about 42 hours and the critical plasma concentration as $2 \times 10^{-8} \text{M}$. Both factors must be exceeded for toxicity to occur to these organs.

Doses of methotrexate resulting in plasma levels in excess of $2 \times 10^{-8} \text{M}$ circulating for greater than 42 hours will be toxic to both the bone marrow and gastrointestinal epithelium. This toxicity can be minimized by the appropriate administration of Leucovorin Calcium.

Methotrexate may be hepatotoxic, particularly at high dosage and with prolonged therapy. Liver atrophy, necrosis, cirrhosis, fatty changes and periportal fibrosis have been reported.

-
1. Cannon GW. Pulmonary Toxicity of Methotrexate. In: William S. Wilke eds. *Methotrexate Therapy in Rheumatic Disease*. Marcel Dekker, Inc. 270 Madison Ave., New York, N.Y. 10016. 1989; 243-260.
 2. Martindale: The Extra Pharmacopoeia. 29th Edition. James E.F. Reynolds ed. London Pharmaceutical Press 1989.
 3. Evans AE, D'Angelo GJ, and Mitus A. Central Nervous System Complications of Children with Acute Leukemia. An Evaluation of Treatment Methods. *J Pediat*. 1964; 6:94-96.
 4. Hertz R, Lewis J Jr., and Lipsett MB. Five Years' Experience with the Chemotherapy of Metastatic Choriocarcinoma and Related Trophoblastic Tumours in Women. *Amer J Ob Gyn*. 1961; 82:631-640.
 5. Li MC. Trophoblastic Disease: Natural History, Diagnosis and Treatment. *Ann. Int. Med*. 1971; 74:102-112.
 6. Krivit W, et al. Induction of Remission in Acute Leukemia of Childhood by Combination of Prednisone and either 6-mercaptopurine or Methotrexate. *J Pediat*. 1966; 68:965-968.
 7. Acute Leukemia Group B.: Acute Lymphocytic Leukemia in Children. *JAMA*. 1969; 207:923-928.
 8. Burchenal JH. Chemotherapy for Leukemia. *Postgrad. Med*. 1970; 48:164-168.
 9. Ziegler JL, et al. Treatment of Burkitt's Tumour with Cyclophosphamide. *Cancer*. 1970; 26:474-484.
 10. Hryniuk WM and Bertino JR. Treatment of Leukemia with Large Doses of Methotrexate and Folinic Acid: Clinical Biochemical Correlates. *J Clin Invest*. 1969; 48:2140-2155.
 11. Hersh EM, Wong VG, Henderson ES, and Freireich EJ. Hepatotoxic Effects of Methotrexate. *Cancer*. 1966; 19:600-606.
 12. Dixon RL, Henderson ES, and Rall DP. Plasma Protein Binding of Methotrexate and its Displacement by Various Drugs. *Fed. Proc*. 1965; 24:454.
 13. Pitman SW and Frei E. Weekly Methotrexate-Calcium Leucovorin rescue: Effect of alkalinization on nephrotoxicity: Pharmacokinetics in the CNS; and use in CNS Non-Hodgkin's lymphoma. *Cancer Treat Repts*. 1977; 61(4):695-701.

14. Rooney TW, Furst De. Comparison of toxicity in Methotrexate (MTX) treated rheumatoid arthritis (RA) patients also taking aspirin (ASA) or other NSAID. Abstract. Arthritis Rheum 29 Suppl 4:S76.
 15. Aherne et al. Br Med J. 1978; 1: 1097-1099.
 16. Freisheim JH, Matthews DA. Dihydrofolate Reductases. Folate Antagonists as Therapeutic Agents. Academic Press Inc. 1984; 1:70-73.
 17. DeVita Jr. LVT, Hellman S, Rosenberg SA. Clinical features of low-grade T-cell lymphomas. Cancer. Principles and Practice of Oncology. 4th. Ed. J.B. Lippincott Co., Philadelphia. pp. 1930-1935.
 18. Link MP, Goorin AM, Miser AW, Green AA, Pratt CB, Belasco JB, Pritchard J, Malpas JS, Baker AR, Kirkpatrick JA, Ayala AG, Shuster JJ, Abelson HT, Simone JV, Vietti TJ. The effect of adjuvant chemotherapy on relapse-free survival in patients with osteosarcoma of the extremity. N Eng J Med. 1986; 314(25):1600-1606.
 19. Stark AN, Jackson G, Carey PJ, Arfeen S, Proctor SJ. Severe renal toxicity due to intermediate-dose Methotrexate. Department of Haematology, Royal Victoria Infirmary, Newcastle-upon-Tyne.
 20. Evans WE, Christensen ML. Drug interactions with Methotrexate. J Rheumatol (Canada). 1985; Suppl 12 12:15-20.
 21. Chabner BA, Collins JM. Cancer chemotherapy principles and practice. Philadelphia: Lippincott, 1990; 449-464.
 22. Nyfors A. Benefits and adverse drug experiences during long-term Methotrexate treatment of 248 psoriatics.
-
23. Roenigk HH Jr, Maibach HI, and Weinstein GD. Use of Methotrexate in Psoriasis. Arch Derm. 1972; 105:363-365.
 24. Roenigk HH Jr, Bergfeld WF, and Curits GH. Methotrexate for Psoriasis in Weekly Oral Doses. Arch Derm. 1969; 99:86-93.
 25. Rees RB, Bennett JH, Maibach HI, and Arnold HL. Methotrexate for Psoriasis. Arch Derm. 1971; 103:33-38.
 26. Roenigk HH Jr, Maibach HI, and Weinstein GD. Methotrexate Therapy for Psoriasis. Arch Derm. 1973; 108:35.
 27. Weinstein GD. Methotrexate for Psoriasis. JAMA. 1973; 225:412.

28. Weinstein GD. Methotrexate for Psoriasis. *Dermatology Digest*. 1973; 12:49-53.
29. Weinstein GD and Velasco J. Selective Action of Methotrexate on Psoriatic Epidermal Cells. *J of Investigative Dermatology*. 1972; 59:121-127.
30. Coe RO and Bull FE. Cirrhosis Associated with Methotrexate Treatment of Psoriasis. *JAMA*. 1968; 206:1515-1520.
31. Weinstein CD, et al. Cooperative Study. Psoriasis-Liver Methotrexate Interactions. *Arch Derm*. 1973; 108:36-42.
32. Pearce HP and Wilson BB. Erosion of psoriatic plaques: An early sign of Methotrexate toxicity. *Am Acad Dermatol*. 1996; 35:835-838.
-
33. Adams JD and Hunter GA. Drug interaction in psoriasis. *Aust J Derm*. 1976; 17:3940.
34. Bloom EJ et al. Delayed clearance (CL) of Methotrexate (MTX) associated with antibiotics and anti-inflammatory agents. Abstract, *Clin Res*. 1986; 34, No. 2:560A.
35. Daly H. et al. Interaction between Methotrexate and non-steroidal anti-inflammatory drugs. *Lancet*. 1986; 557.
36. Daly H, et al. Methotrexate toxicity precipitated by azapropazone. *Br J Derm*. 1986; 114:733-735.
37. Doolittle GC, et al. Early-onset pancytopenia in two patients with rheumatoid arthritis receiving low-dose Methotrexate. Abstract 15C, *Art. Rheum* 1987; 30:S19, 1 Suppl.
38. Ellison NM, and Servi RJ. Acute renal failure and death following sequential intermediate-dose Methotrexate and 5-FU: A possible adverse effect due to concomitant Indomethacin administration. *Cancer Treat Reps*. 1985; 69(3):342-343.
39. Gabrielli A, et al. Methotrexate and non-steroidal anti-inflammatory drugs. Letter, *Br Med J*. 1987; 294:776.
40. Maiche AI. Acute renal failure due to concomitant action of Methotrexate and Indomethacin. Letter, *Lancet*. 1986; 1390.
41. Mandel MA. The synergistic effect of salicylates on Methotrexate toxicity. *Plastic and Reconstructive Surg*. 1976; 733-737.

42. Singh RR, et al. Fatal interaction between Methotrexate and Naproxen. Letter, Lancet. 1986; 1390.
43. Thyss A, et al. Clinical and pharmacokinetic evidence of a life-threatening interaction between Methotrexate and Ketoprofen. Lancet. 1986; 256-258.
-
44. Turner SL, et al. Radical external beam radiotherapy of r333 squamous carcinomas of the oral cavity-Evaluation of the late morbidity and a watch policy for the clinically negative neck. Radiotherapy & Oncology. 1996; 41:21-9.
-
45. Wall SM, et al. Effective clearance of Methotrexate using high-flux hemodialysis membranes. Am J Kidney Dis. 1996; 28(6):846-854.
-
46. Kremer JM, et al. Methotrexate for rheumatoid arthritis. Suggested guidelines for monitoring liver toxicity. American College of Rheumatology. Arthritis & Rheumatol. 1994; 37(3):316-328.
47. Goodman TA, et al. Methotrexate: adverse reactions and major toxicities. Rheumatic Disease Clinics of North America. 1994; 20(2):513-28.
48. Tett SE, et al. Use of Methotrexate in older patients. A risk-benefit assessment. Drugs & Aging. 1996; 9(6):458-71.
49. Said S, et al. Systemic treatment: Methotrexate. Clinics in Dermatology. 1997; 15(5):781-97.
50. Evans WE, et al. Applied Pharmacokinetics: Principles of therapeutic drug monitoring, 3rd ed. Applied Therapeutics, Inc. Vancouver WA, 1992.
51. Green JA, et al. Drug interactions with cytotoxic agents. Cancer Topics. 1990; 7(11); 126-128.
52. Nierenberg W, et al. Toxic reaction to Methotrexate in a patient receiving penicillin and furosemide: a possible interaction. Arch-Dermatol. 1983; 119(6): 449-50.
53. Squire EN, et al. Unexpected adverse effects of Methotrexate (MTX) when used in the treatment of steroid-dependent asthma. Ann Allergy-Asthma-Immunol. 1996; 76(1):106 (Abs).
54. Glynn Barnhart AM, et al. Effect of low-dose Methotrexate on the deposition of glucocorticoids and theophylline. J Allergy Clin Immunol. 1991; 88(2):180-86.

55. Glynn Barnhart AM, et al. Effect of Methotrexate on prednisolone and theophylline pharmacokinetics. *Pharmacotherapy*. 1990; 10(3):255.
56. Yokoo H, Nakazato Y, Harigaya Y, et.al. Massive myelinolytic leukoencephalopathy in a patient medicated with low-dose oral methotrexate for rheumatoid arthritis: an autopsy report. *Acta Neuropathol*. 2007;114:425-430.
57. Worthley S, McNeil J. Leukoencephalopathy in a patient taking low dose oral methotrexate therapy for rheumatoid arthritis. *J Rheumatol*. 1995; 22:335-337.
58. Renard D, Westhovens R, Vandebussche E, et al. Reversible posterior leukoencephalopathy during oral treatment with methotrexate. *J Neurol*. 2004; 251: 226- 228.
59. Raghavendra S, Nair MD, Chemmanam T, et al. Disseminated necrotizing leukoencephalopathy following low-dose oral methotrexate. *Eur J Neurol*. 2007; 14:309-314.
60. Electronic communication from Yasuo Sugano, Labeling Group, PV Dept. Medical Affairs, WKK; 01 August 2008.
61. Williams HJ, Willkens RF, Samuelson CO et al. Comparison of low dose oral pulse Methotrexate and placebo in the treatment of rheumatoid arthritis. *Arthritis Rheum*. 1985; 28: 721, 1985.
62. Visser K, van der Heijde D. Optimal dosage and route of administration of methotrexate in rheumatoid arthritis: a systemic review of the literature. *Ann Rheum Dis*. 2009; 68: 1094-1099.
63. ^{Pr}pms-Methotrexate (Methotrexate Tablets USP) Product Monograph. Pharmascience Inc. Date of Revision: May 16, 2019. Submission Control Number: 224788.

Polysorbate 80,
Microcrystalline cellulose, and
Starch pregelatinized (Prejel PA5)

Tablet: 10 mg



Methotrexate Tablets, USP belongs to a group of medicines known as antimetabolites. It is used to treat certain types of cancers, severe psoriasis and severe rheumatoid arthritis.

Methotrexate Tablets, USP works by blocking an enzyme needed by body cells to live. This interferes with the growth of some cells, such as skin cells in psoriasis that are growing rapidly. In rheumatoid arthritis, Methotrexate Tablets, USP acts on the inflammatory cells that cause joint swelling. Methotrexate Tablets, USP therapy is used to control psoriasis and rheumatoid arthritis but it will not cure them. In cancer, Methotrexate Tablets, USP works by blocking an enzyme process in cancer cells so that they cannot grow. Some normal cells in the body may be affected as well.

Do not take Methotrexate Tablets, USP if you:

- Are allergic to any component of the drug
- Have severe kidney problems
- Are on dialysis
- Are pregnant. Methotrexate Tablets, USP can cause harm to your unborn baby. Women of childbearing potential should not be started on Methotrexate Tablets, USP until pregnancy is excluded
- Are breast-feeding
- Have psoriasis or rheumatoid arthritis and the following:
 - alcoholism (drink excessive alcohol)
 - chronic liver disease
 - immunodeficiency (resistance to infectious diseases is reduced)
 - blood disorders
- Are going to receive a general anesthetic called nitrous oxide. It is also known as laughing gas.

Methotrexate (meth-o-TREX-ate).

Maize starch,
Lactose monohydrate,
Magnesium stearate,

Methotrexate Tablets, USP should be prescribed by a doctor who is experienced with the use of antimetabolite therapy.

- Methotrexate Tablets, USP can cause serious toxic reactions which may result in death.
- Methotrexate Tablets, USP can cause birth defect (deformed babies) or death of an unborn baby when used in pregnant women. Pregnant women with psoriasis or rheumatoid arthritis should not take Methotrexate Tablets, USP.

Before you use Methotrexate Tablets, USP, talk to your doctor or pharmacist if you have any of the following conditions:

- have or have had any unusual or allergic reaction to Methotrexate Tablets, USP
- are pregnant or planning to become pregnant. Methotrexate Tablets, USP can cause birth defects (deformed babies) or death of an unborn baby. Both male and female patients must use effective birth control methods all the time while taking Methotrexate Tablets, USP and a few months after the last dose of the drug. Methotrexate Tablets, USP may cause sterility (infertility), which could be permanent. Be sure to discuss this with your doctor before taking Methotrexate Tablets, USP. Tell your doctor right away if you think you have become pregnant while taking Methotrexate Tablets, USP.
- are breast-feeding or plan to breast-feed. Methotrexate Tablets, USP may cause serious side effects. Do not breastfeed while you are taking the drug
- have kidney problems
- have or have had liver problems, including hepatitis B or hepatitis C infection
- have lung problems
- have problem with your immune system, or infections
- have gastrointestinal problems such as vomiting, diarrhea, mouth sores or inflammation, ulcer, or colitis (ulcer of the intestines)
- are dehydrated or have a lot of vomiting, diarrhea, or sweating
- have a skin disease
- have a neurologic disorder
- drink alcohol

Methotrexate Tablets, USP increases sensitivity to sunlight. Avoid sun exposure and do not use a sunlamp while taking this drug.

- Each time you refill your prescription, check to see whether the dose and/or the number of tablets you need to take have changed.

Methotrexate Tablets, USP is often given together with certain other medicines. If you are using a combination of medicines, make sure that you take each one at the proper time and do not mix them. Ask your doctor or pharmacist to help you plan a way to remember to take your medicines at the right times.

While you are using Methotrexate Tablets, USP, your doctor may want you to drink extra fluids so that you will pass more urine. This will help the drug to pass from the body, and will prevent kidney problems and keep your kidneys working well.

If you vomit shortly after taking a dose of Methotrexate Tablets, USP, check with your doctor. You will be told whether to take the dose again or to wait until the next scheduled dose.

The dose of Methotrexate Tablets, USP will be different for different patients. The dose that is used may depend on a number of things, including what the medicine is being used for, the patient's size and whether or not other medicines are also being taken. The doctor may decrease your dose if you have problems with your kidneys. If you are taking or receiving Methotrexate Tablets, USP at home, follow your doctor's orders or the directions on the label. If you have any questions about the proper dose of Methotrexate Tablets, USP, ask your doctor.

If you think you have taken too much Methotrexate Tablets, USP, contact your healthcare professional, hospital emergency department, or regional Poison Control Centre immediately, even if there are no symptoms.

- Do this even if you have no signs of discomfort.
- Always take the labelled medicine bottle with you, even if it is empty.
- If you missed a scheduled dose, contact your doctor for instruction.

Along with their needed effects, medicines like Methotrexate Tablets, USP can cause unwanted effects. Also, because of the way these medicines act on the body, there is a chance that they might cause other unwanted effects that may not occur until months or years after the medicine is used. These delayed effects may include certain types of cancer, such as leukemia. Discuss these possible effects with your doctor.

Methotrexate Tablets, USP commonly causes nausea and vomiting. Even if you begin to feel ill, do not stop using this

medicine without first checking with your doctor. Ask your doctor for ways to lessen these effects.

The most common side effects include:

- Upset stomach, stomach pain, vomiting, nausea, loss of appetite, dizziness, chills and fever, diarrhea or sores on lips or mouth
- A fall in the number of white blood cells. This may reduce your resistance to infection and increase your chances of cold sores, blood poisoning or swelling of blood vessels.
- Tiredness (fatigue)

Less common side effects are:

- Headaches, hair loss, mood changes, confusion, ringing in the ears, sore eyes, skin rashes, increased sensitivity to sunlight or unexplained weight loss
- A fall in the number of other blood cells. This may increase your chances of bruising, bleeding or tiredness
- Damage to the lungs
- Harm to the unborn baby
- Convulsions

Rarely, Methotrexate Tablets, USP can cause other side effects including:

- Liver damage, kidney damage, pain or difficulty urinating, lower back or side pain, blood in urine or stools, dark urine
- Fits, blurred vision, short term blindness
- Drowsiness, weakness
- Hoarseness
- Bloody vomit, black, tarry stools or pin-point red spots on the skin
- Reddening or whitening of the skin, acne, boils, itching yellow skin or eyes
- Impotence or loss of interest in sex, decreased fertility, abortion
- Diabetes, thinning of the bones, painful muscles and joints
- Low blood pressure
- Gastrointestinal ulcers

More rarely, it can cause:

- Skin rash and other skin disorders
- Cancer of lymph glands, sudden death
- Severe allergic reactions
- Leukoencephalopathy
- Damage to heart

Methotrexate can cause abnormal test results. Your doctor will decide when to perform tests and will interpret the results. This includes blood and urine tests to check how your kidneys are working.

	Diarrhea, vomiting, abdominal pain, or mouth ulcers			
	Sore throat, fever, chills, or swelling of glands			
	: Persistent dry, non-productive cough, shortness of breath and fever.			
	Chest pain, cough, shortness of breath or fever			
	Unusual bleeding or bruising			
	Severe headaches			
	Signs of severe allergic reaction: Skin rash, itching, chest tightness, wheezing, dizziness, hives, faintness, rapid heartbeat, shortness of breath, and/or a swollen face, lips or tongue			
	Pain or difficulty urinating, lower back or side pain, blood in urine or stools, dark urine			
	Yellow colour of eyes or skin			
	<input type="checkbox"/> swelling of the hands, ankles or feet. Nausea, vomiting. Blood in the urine. Changes in frequency or amount of urine.			

	Severe abdominal pain, tenderness, chills, fever, nausea, vomiting, extreme thirst, difficulty passing urine or bowel movement			
	Behaviour changes, decreased consciousness, headache, weakness, numbness, vision loss or double vision, seizures, vomiting, loss of memory			
	<input type="checkbox"/> Fever, rash, hives, swelling of eyes, lips or tongue			
	suddenly spit or cough up blood			

This is not a complete list of side effects. For any unexpected effects while taking Methotrexate Tablets, USP, contact your doctor or pharmacist.

You can report any suspected side effects associated with the use of health products to Health Canada by:

- Visiting the Web page on Adverse Reaction Reporting (<https://www.canada.ca/en/health-canada/services/drugs-health-products/medeffect-canada/adverse-reaction-reporting.html>) for information on how to report online, by mail or by fax; or
- Calling toll-free at 1-866-234-2345.

NOTE: Contact your health professional if you need information about how to manage your side effects. The Canada Vigilance Program does not provide medical advice.

- Keep out of the reach and sight of children.
- Store Methotrexate Tablets, USP between 15°C and 25°C, away from heat and direct light. Keep the tablet container in the outer carton in order to protect from light.
- Do not keep outdated medicine or medicine no longer needed. Be sure that any discarded medicine is out of the reach and sight of children.

NOTE: This Consumer Information provides you with the most current information at the time of printing.

The full Product Monograph prepared for health professionals can be found by contacting the sponsor, Pfizer Canada ULC, at 1-800-463-6001.

This leaflet was prepared by:

Pfizer Canada ULC
Kirkland, Québec H9J 2M5

Last revised: September 12, 2019