Northern Lincolnshire and Goole NHS
NHS Foundation Trust

Prescribing Framework for Azathioprine in Rheumatic Diseases

Patient's Name:…… Unit Number: ……

Patient's Address:……(Use addressograph sticker)

GP's Name:……..

Communication

We agree to treat this patient within this Prescribing Framework. Consultant's Signature:…….. GP's Signature:…….

If the General Practitioner is unable to accept prescribing responsibility for the above patient the consultant should be informed within one week of receipt of this framework and consultant's / nurse specialist's letter. In such cases the GP are requested to update the consultant, by letter, of any relevant changes in the patient's medication / medical condition.

APPROVAL PROCESS

Written by:	**Dr Tim Gillott, Consultant Rheumatologist**
Monitoring Guidance:	**Yorkshire Monitoring Guidelines 2014**
Approved by:	**Northern Lincolnshire and Goole Medicines and Therapeutics Committee**
Ratified by:	**Northern Lincolnshire Area Prescribing Committee**
Review date:	**May 2021**

Background

DMARDs are fundamental to arresting the disease process in Rheumatoid Arthritis and other inflammatory arthritides. While early initiation of therapy is essential to arrest the disease process, sustained use is vital if disease suppression is to be maintained. Prolonged therapy requires long-term monitoring for toxicity and safety profile

Azathioprine is a DMARD that may be used for rheumatoid arthritis (NICE Clinical Guideline 79, www.nice.org.uk/cg79) and other rheumatic diseases e.g. S.L.E. and vasculitis.

These guidelines aim to provide a framework for the prescribing of Azathioprine by GPs and to set out the associated responsibilities of GPs and hospital specialists who enter into the shared care arrangements.

AZATHIOPRINE	
Dose:	Treatment is usually started at one 50mg tablet daily with or after breakfast for the first week. Subsequently, if no problems occur, the dose is usually increased weekly to 100mg daily and then 150mg daily, taken at the same time or in divided doses with meals. The dose is usually increased up to 2.5mg/kg per day and occasionally more if needed.
Baseline Tests:	FBC/U&E/LFT Consider TPMT Consider Hepatitis B and C Consider Pregnancy test
Routine Monitoring:	Repeat FBC/U&E/LFT: 2 weekly for 2 months (0-2 months) Monthly for 4 months (2-6 months) Then 3 monthly (assuming dose stable) (*Consider more frequently if high dosage or if renal or hepatic impairment). Patients could be guided to have a blood test (e.g. for CRP) just prior to their secondary care appointment.
Indications for stopping:	Stop medication and contact the Rheumatology service if: WCC <3.5 $10^{9/}$L or below local normal range Neutrophils < 2.0 $10^{9/}$L or below local normal range Platelets <150 $10^{9/}$L or below local normal range AST or ALT > 3 times normal range (iu/L) Mouth or throat ulceration Unexplained bruising or bleeding Fever/nausea/vomiting/diarrhoea Diffuse alopecia
Assessment of Response:	Refer to hospital specialist - time to response 6 weeks to 3 months
Additional information:	• Patients deficient in thiopurine methyltransferase (TPMT) enzyme are at increased risk of haematological toxicity • Renal or hepatic dysfunction – consider need for dose reduction to avoid haematological toxicity. • Live vaccines should not be administered + avoid for 6 months after stopping. Zoster vaccine may be considered when dosage is low. • Consider check Varicella Zoster Virus status • Surveillance for skin cancer - monitoring of skin for any new

	lesions and/or changes. Provide advice on sunscreen and protective clothing. <u>Important drug reactions:</u> ●Allopurinol, oxypurinol and thiopurinol - reduced elimination of azathioprine and 6-mercaptopurine, reduce dose by one quarter of original dose. ● Warfarin - reduced anticoagulant effect. ●Captopril and possibly other ACE inhibitors - increased risk of myelosuppression. ● Co-trimoxazole and trimethoprim - increased risk of myelosuppression. ●Clozapine - increased risk of agranulocytosis. ●Sulfasalazine, mesalazine and olsalazine - possible increased risk of leucopenia.
Pregnancy & Breastfeeding:	Please contact the Rheumatologist if patient considering conceiving or in case of pregnancy. • Azathioprine may be continued during pregnancy and when breastfeeding where the benefit is deemed to outweigh potential risk e.g. in SLE or colitis
Please refer to licensed datasheet for more comprehensive prescribing information: http://www.medicines.org.uk/EMC/medicine/2881/SPC/Imuran+Tablets+25mg/	

Responsibilities of clinicians involved

Stage of Treatment	Hospital Specialist	General Practitioner
Initiation	Assess the patient following referral by GP Recommend appropriate treatment to the GP Carry out baseline full blood count, differential WCC, platelets, U&Es and LFTs Give patient a DMARD alert card which records the name of the medicines started and dose. Prescribe first month of treatment	
Maintenance	Assess clinical response to treatment Provide adequate advice and support for the GP. Provide information to GP on frequency of monitoring if doses are changed Update DMARD alert card where relevant.	Prescribe on FP10 Monitor for adverse effects, refer to consultant where necessary. Blood tests for monitoring as above Patients should be asked about the presence of rash or oral ulceration at each visit.

Contact Details:

Rheumatology Specialist Nurses: 03033 304849