

WELLCOVORIN® TABLETS (leucovorin calcium)

Leucovorin in convenient
5 mg and 25 mg tablets

Before prescribing WELLCOVORIN® Tablets, please consult complete prescribing information. The following is a brief summary.

INDICATIONS AND USAGE: Wellcovorin (leucovorin calcium) is indicated for the prophylaxis and treatment of undesired hematopoietic effects of folic acid antagonists (see WARNINGS).

CONTRAINDICATIONS: Leucovorin is improper therapy for pernicious anemia and other megaloblastic anemias secondary to the lack of vitamin B₁₂. A hematologic remission may occur while neurologic manifestations remain progressive.

WARNINGS: In the treatment of accidental overdosage of folic acid antagonists, leucovorin should be administered as promptly as possible. As the time interval between antifolate administration (e.g. methotrexate) and leucovorin rescue increases, leucovorin's effectiveness in counteracting hematologic toxicity diminishes.

PRECAUTIONS:

General: Following chemotherapy with folic acid antagonists, parenteral administration of leucovorin is preferable to oral dosing if there is a possibility that the patient may vomit and not absorb the leucovorin. In the presence of pernicious anemia a hematologic remission may occur while neurologic manifestations remain progressive. Leucovorin has no effect on other toxicities of methotrexate, such as the nephrotoxicity resulting from drug precipitation in the kidney.

Drug Interactions: Folic acid in large amounts may counteract the antiepileptic effect of phenobarbital, phenytoin and primidone, and increase the frequency of seizures in susceptible children.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Animal reproduction studies have not been conducted with Wellcovorin. It is also not known whether Wellcovorin can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Wellcovorin should be given to a pregnant woman only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when Wellcovorin is administered to a nursing mother.

Pediatric Use: See "Drug Interactions".

ADVERSE REACTIONS: Allergic sensitization has been reported following both oral and parenteral administration of folic acid.

OVERDOSAGE: Excessive amounts of leucovorin may nullify the chemotherapeutic effect of folic acid antagonists.

DOSAGE AND ADMINISTRATION: Leucovorin is a specific antidote for the hematopoietic toxicity of methotrexate and other strong inhibitors of the enzyme dihydrofolate reductase. Leucovorin rescue must begin within 24 hours of antifolate administration. A conventional leucovorin rescue dosage schedule is 10 mg/m² orally or parenterally followed by 10 mg/m² orally every six hours for seventy-two hours. If, however, at 24 hours following methotrexate administration the serum creatinine is 50% or greater than the pre-methotrexate serum creatinine, the leucovorin dose should be immediately increased to 100 mg/m² every three hours until the serum methotrexate level is below $5 \times 10^{-8}M$.^{1,2}

The recommended dose of leucovorin to counteract hematologic toxicity from folic acid antagonists with less affinity for mammalian dihydrofolate reductase than methotrexate (i.e. trimethoprim, pyrimethamine) is substantially less and 5 to 15 mg of leucovorin per day has been recommended by some investigators.^{3,4,5}

1. Bleyer WA: The Clinical Pharmacology of Methotrexate. *Cancer*, 41(1):36-51, 1978.
2. Frei E, Blum RH, Pitman SW, et al: High Dose Methotrexate with Leucovorin Rescue: Rational and Spectrum of Antitumor Activity. *Am J Med*, 68:370-376, 1980.
3. Golde DW, Bersch N, Quan SG: Trimethoprim and Sulpha-methoxazole Inhibition of Haematopoiesis in Vitro. *Br J Haematol*, 40(3): 363-367, 1978.
4. Steinberg SE, Campbell CL, Rabinovitch PS, et al: The Effect of Trimethoprim/Sulfamethoxazole on Friend Erythroleukemia Cells. *Blood*, 55(3): 501-504, 1980.
5. Mahmoud AAF and Widren KS: Algorithms in the Diagnosis and Management of Exotic Disease. XX Toxoplasmosis. *J Infect Dis*, 135(3): 493-496, 1977.



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HOSPICE NEWS... A REPORT FROM HOSPICE ASSOCIATION OF AMERICA



Anne Katterhagen, R.N.
Chairman of the Board

The Hospice Association of America (HAA) is a membership organization established in 1985, through the joint efforts of the Association of Community Cancer Centers and the National Association for Home Care (NAHC). HAA was established as a representative for the full range of hospice programs: health agency and hospital-based programs. After only two years, the Association's members number over 1200, and reflect the highly diverse field of hospice care providers, health care professionals, volunteers, and others involved in, and supportive of, providing care to the dying and their families.

One important function of HAA is serving as a research and information source for its members, the public, and policymakers. The Association monitors and analyzes public policy trends affecting hospice and seeks to influence the direction of federal and state legislation and regulation affecting hospice. The Association disseminates the results of its research and other information through a variety of means, including the **Hospice Forum**, a biweekly newsletter. The Forum publishes the latest information on Federal and state legislative and regulatory activity, membership news, and other hospice-related news.

On the regulatory front, HAA has been involved with its sister organization, NAHC, in a lawsuit against the Department of Health and Human Services. The suit, filed in conjunction with Congressmen, beneficiaries, and physicians protests the rapidly escalating rate of arbitrary denials of home health claims nationwide.

Legislative priorities for HAA this year include:

- 1) The organization seeks improvement of the Medicare hospice benefit through coverage of in-home respite care. The current benefit limits respite care to the inpatient setting at the reimbursement rate of \$65.33 per day, and there is no in home respite care benefit.
- 2) HAA recommends that the government finance a humane system of care for AIDS patients, whether it be through changing the current Medicare two-year disability requirement to more accurately reflect AIDS patients' life expectancies, or through block grants to states. HAA will work to see that barriers to hospice services in Medicare and Medicaid such as requiring a primary caregiver, certification of terminality, a life expectancy of six months, and only palliative treatment should be waived.
- 3) HAA will work to see that hospice benefits be made available to children under the Medicare program. Children are not eligible for such coverage unless they have been covered under Social Security disability for two years. Mandated Medicaid coverage should include coverage of pediatric hospice services as well.

In addition to being a voice for hospice in legislative and regulatory matters, HAA functions as an educational resource. The Association sponsors special educational programs throughout the year. For example, in March, 1987, HAA held its annual Spring conference in Washington, D.C. Over 200 members registered for a day of speakers on timely issues in hospice care. Participants heard JCAH representative Anne Rooney speak on quality assurance in hospice, and listened to panel presentations on pain management and on pediatric AIDS.

HAA's success comes from the strength of its diverse membership. Because it represents the entire spectrum of hospice providers, HAA offers an excellent forum for the sharing of differing ideas and hospice care delivery models. United in their commitment to the hospice concept of specialized care for the terminally ill, these diverse members can speak with the single strong voice of HAA.