New Zealand Rheumatology Association

Methotrexate Prescribing Position Statement for Family Planning August 2025

Maternal Methotrexate

Methotrexate is a known teratogen. As such, reliable contraception should be discussed with and prescribed to all women of child bearing potential. Long-acting reversible contraception (LARC) is preferred, as it carries the lowest risk of unintended pregnancy for our rheumatology patients.

Methotrexate may be used in women planning pregnancy more than 12 months in the future, provided there is a planned withdrawal of methotrexate with appropriate contraception. Women should discontinue methotrexate at least 3 months before trying to conceive and receive at least 1 month of daily folic acid supplementation (5 mg/day) before stopping contraception.

If conception occurs inadvertently while on methotrexate, the risk of congenital malformations is increased to approximately 6.6% (compared to a baseline risk of 3–5%). These risks should be discussed with the patient by a suitably qualified clinician, and pregnancy termination should be discussed and a decision around this should be supported according to the patient's informed choice.

Paternal Methotrexate

Multiple studies including meta-analysis of paternal methotrexate use have not shown any negative association with quality of sperm or evidence of foetal harm. Active autoimmune rheumatic disease is more likely to have a detrimental effect on fertility, as such, males on methotrexate hoping to father offspring should be advised to continue on methotrexate. Multiple international guidelines on reproductive health endorse continuation of methotrexate in males.

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