Table SIV. *Aggregated evidence*

	BSR/BHPR (18) (UK, 2008)	NICE (22) (UK, 2012)	Update S3 guideline (21) (Germany, 2012)	European S3 guideline (20) (EU, 2009)	Guideline psoriasis (27) (The Netherlands, 2011)	AAD guideline (2) (US, 2009)	Guideline MTX in psoriasis (19) (Spain, 2010)	SR Treatment modalities (3)	Consensus conference NPF 2009 (6)	Consensus report TTP 2013 (28)
Test-dose	Not mentioned	Not mentioned	Not mentioned	2.5 mg in elderly patients	2.5–5 mg can be considered (no consensus)	2.5–5 mg recommended	Recommended in patients with a relative contraindication and elderly patients	Not mentioned	5–15 mg mandatory in patients with decreased glomerular filtration rate or risks for haematological toxicity	Not mentioned
Start-dose Single/ Weinstein	5–10 mg/week Single	5–10 mg/week Not mentioned	7.5–15 mg/week Weinstein (no clear evidence)	5–10 mg/week Single or Weinstein (no evidence)	5–10 mg/week Single or Weinstein (no evidence)	Not mentioned Single	Not mentioned Single or Weinstein (no evidence)	5–10 mg/week Not mentioned	7.5–15 mg/week Single or Weinstein	5–15 mg/week Single or Weinstein (no evidence)
Dose increments	2.5–5 mg increments every 2–6 weeks until stable disease	Gradually increase up to an effective dose. Assessment after 3 months on target dose.	Increase up to 22.5 mg/week depending on treatment response	Not mentioned	Depending on response increment up to 15 mg/week, perhaps to 22.5 mg/week	Dose increase until optimal response. Effect of dose increase noticeable after 4 weeks.	Lower the dose when treatment goal is reached	Rapid dose increase over 4 weeks to reach a target therapeutic dose between 15–25 mg/week	Dose ↑↓ to obtain adequate control. It can take 4–8 weeks to determine the result of a dose change	In case of low MTX start dose, rapid ↑ to 15 mg/ week at week 3 and if necessary and possible to 20 mg/week at week 8
Max dose FA	25 mg/week 5 mg the day after MTX	25 mg/week Effect of FA on efficacy and AEs is unclear.	22.5 mg/week 1–5 mg on non-MTX days with maximum of 20 mg/week. Perhaps no FA during induction phase	30 mg/week There is evidence that FA might reduce AEs without affecting efficacy	30 mg/week 1 mg/day except on MTX days till 5–10 mg/week 24 h after MTX administration. (In RA: MTX < 15 mg: 5 mg FA, MTX ≥ 15 mg: 10 mg FA)	25 mg/week 1–5 mg/day except on the day of MTX administration	30 mg/week FA only in patient with FA deficiency or high need patients (infectious disease, use of certain antibiotics)	25 mg/week 5 mg/day for 1–3 days to be taken 48 h after MTX dose	25 mg/week Adding FA to MTX treatment is beneficial. An options is 1 mg daily	Not mentioned Often recommended though there is little evidence about its effect on tolerability of MTX

MTX: methotrexate; FA: folic acid; AE: adverse event; AAD: American Association of Dermatologists; SR: systematic review; NPF: National Psoriasis Foundation; TTP: Transitioning Therapies Program; BSR/BHPR: British Society for Rheumatology/British Health Professionals in Rheumatology; NICE: National Institute for Health and Care Excellence; RA: rheumatoid arthritis.