Considerations when switching Warfarin to Pradaxa

Patient has one of the following indications

- □ Non Valvular Atrial Fibrilation/Flutter + CHADsVASc $\geq$ 2
- □ Reduction in primary risk following hip surgery for up to 35 days [A (75 mg BID)]
- □ Reduction in recurrence risk following treatment of provoked DVT for up to 3 months
- □ Reduction in recurrence risk following treatment of unprovoked DVT for up to 6 months
- □ Reduction in recurrence risk following treatment of multiple unprovoked DVTs indefinitely

Patient's creatinine clearance is measured

- □ Above 30 ml/min
- □ Between 15-30 ml/min + indicated for non-valvular atrial fibrillation + CHADsVASc $\geq$ 2 [B (220 mg daily)]

Patient does not have any of the following

- ❖ Active pregnancy/Lactation
- ❖ Valvular heart disease (Mitral Valve Stenosis, Mechanical Valve, Rheumatic Heart Disease)
- ❖ Non modifiable drug interaction risk (PGP substrate)
- ❖ Decompensated liver disease (Child Pugh B with elevated INR, Child Pugh C)
- ❖ Older than 75 years old (unpredictable safety)
- ❖ Greater than 65 years old & CrCl <30ml/min (avoid due to increased bleed risk)
- ❖ History or significant risk of GI Bleed

Consider other therapies first if patient has

- ❖ History of acute coronary syndrome (Dabigatran increases risk)
- ❖ Genetic thrombophilia (antiphospholipid syndrome, factor V Leiden, protein C deficiency, protein S deficiency, lupus, etc).
    - o CHEST guidelines currently recommend Warfarin first line. Safety and efficacy among thrombophelias is demonstrated with Dabigatran among patients identified with thrombophilia who were treated in RECOVER, RECOVER II, and REMEDY trials. Use is reasonable in the setting of warfarin intolerance (peripheral necrosis)
- ❖ BMI > 40kg/m2 or weight > 120kg (ISTH 2016 Guidelines)
- ❖ Reduction in recurrence risk following Cardioembolic Stroke with LV mural thrombus formation for 3 months (VKA indicated by 2014 guidelines; DOAC/LMWH preferred when EF < 40% and patient is intolerant to warfarin)
- ❖ Reduction in recurrence risk following Cardioembolic Stroke in the setting of acute anterior STEMI without demonstratable LV mural thrombus formation but with anterior apical akinesis or dyskinesis for 3 months (VKA indicated by 2014 guidelines; DOAC/LMWH preferred when EF < 40% and patient is intolerant to warfarin)

Prescribing considerations

- ➢ Co-administration with aspirin doubles-triples risk of GI bleed
    - o 2014 Stroke guidelines state that "administration of oral anticoagulation with antiplatelet therapy is not recommended for all patients after ischemic stroke or TIA but is reasonable in patients with clinically apparent CAD, particularly an acute coronary syndrome or stent placement (Class IIb; Level of Evidence C)"
- ➢ Use in renal impairment and elderly increases bleed risk
- ➢ Counsel all patients
    1. Take with full glass of water
    2. Store in original package; open containers should be discarded after 4 months (after 30-60 days?)
    3. Do not open capsules; taking in this manner increases absorption 75%
    4. D/c 1-2 days before surgery (CrCl > 50) or 3-5 days if CrCl < 50
    5. Skip missed dose if it is 6 hours past due

Monitoring parameters

- ➢ Test Hgb, HCt, SCr at baseline, when clinically indicated, and annually
- ➢ Signs of bleeding

Considerations when switching Warfarin to Eliquis

Patient has one of the following indications

- □ Non Valvular Atrial Fibrilation/Flutter + CHADsVASc $\geq$ 2
- □ Reduction in primary risk following hip surgery for up to 35 days [A (75 mg BID)]
- □ Reduction in recurrence risk following treatment of provoked DVT for up to 3 months
- □ Reduction in recurrence risk following treatment of unprovoked DVT for up to 6 months
- □ Reduction in recurrence risk following treatment of multiple unprovoked DVTs indefinitely

Patient's creatinine clearance is measured

- □ Above 25 ml/min

Patient does not have any of the following

- ❖ Active pregnancy/Lactation
- ❖ Valvular heart disease (Mitral Valve Stenosis, Mechanical Valve, Rheumatic Heart Disease)
- ❖ Non modifiable drug interaction risk (3A4 and PGP substrate)
- ❖ Decompensated liver disease (Child Pugh C)

Consider other therapies first if patient has

- ❖ Genetic thrombophilia (antiphospholipid syndrome, factor V Leiden, protein C deficiency, protein S deficiency, lupus, etc).
- ❖ BMI > 40kg/m2 or weight > 120kg (ISTH 2016 Guidelines)
- ❖ Reduction in recurrence risk following Cardioembolic Stroke with LV mural thrombus formation for 3 months (VKA indicated by 2014 guidelines; DOAC/LMWH preferred when EF < 40% and patient is intolerant to warfarin)
- ❖ Reduction in recurrence risk following Cardioembolic Stroke in the setting of acute anterior STEMI without demonstratable LV mural thrombus formation but with anterior apical akinesis or dyskinesis for 3 months (VKA indicated by 2014 guidelines; DOAC/LMWH preferred when EF < 40% and patient is intolerant to warfarin)

Prescribing considerations

- ➢ Co-administration with aspirin doubles-triples risk of GI Bleed
  - o 2014 Stroke guidelines state that "administration of oral anticoagulation with antiplatelet therapy is not recommended for all patients after ischemic stroke or TIA but is reasonable in patients with clinically apparent CAD, particularly an acute coronary syndrome or stent placement (Class IIb; Level of Evidence C)"
- ➢ Counsel all patients
  - o Missed dose: administer ASAP same day

Monitoring parameters

- ➢ Test Hgb, HCt, SCr at baseline, when clinically indicated, and annually
- ➢ Signs of bleeding

Considerations when switching Warfarin to Xarelto

Patient has one of the following indications

- □ Non Valvular Atrial Fibrilation/Flutter + CHADsVASc $\geq$ 2
- □ Reduction in primary risk following hip surgery for up to 35 days [A (75 mg BID)]
- □ Reduction in recurrence risk following treatment of provoked DVT for up to 3 months
- □ Reduction in recurrence risk following treatment of unprovoked DVT for up to 6 months
- □ Reduction in recurrence risk following treatment of multiple unprovoked DVTs indefinitely

Patient's creatinine clearance is measured

- □ Above 30 ml/min

Patient does not have any of the following

- ❖ Active pregnancy/Lactation
- ❖ Valvular heart disease (Mitral Valve Stenosis, Mechanical Valve, Rheumatic Heart Disease)
- ❖ Non modifiable drug interaction risk (3A4 and PGP substrate)
- ❖ Liver disease (Child Pugh B, Child Pugh C)

Consider other therapies first if patient has

- ❖ Genetic thrombophilia (antiphospholipid syndrome, factor V Leiden, protein C deficiency, protein S deficiency, lupus, etc)
- ❖ Reduction in recurrence risk following Cardioembolic Stroke with LV mural thrombus formation for 3 months (VKA indicated by 2014 guidelines; DOAC/LMWH preferred when EF < 40% and patient is intolerant to warfarin)
- ❖ Reduction in recurrence risk following Cardioembolic Stroke in the setting of acute anterior STEMI without demonstratable LV mural thrombus formation but with anterior apical akinesis or dyskinesis for 3 months (VKA indicated by 2014 guidelines; DOAC/LMWH preferred when EF < 40% and patient is intolerant to warfarin)

Prescribing considerations

- ➢ Co-administration with aspirin doubles-triples risk of GI bleed
    - o 2014 Stroke guidelines state that "administration of oral anticoagulation with antiplatelet therapy is not recommended for all patients after ischemic stroke or TIA but is reasonable in patients with clinically apparent CAD, particularly an acute coronary syndrome or stent placement (Class IIb; Level of Evidence C)"
- ➢ Counsel all patients
    1. Take with full glass of water
    2. Missed dose: Take as soon as patient remembers on the same day.
    3. Consider renal function and age (elderly patients have a prolonged half-life for xarelto)

Monitoring parameters

- ➢ Test Hgb, HCt, SCr at baseline, when clinically indicated, and annually
- ➢ Signs of bleeding