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| **APIXABAN: Increased anticoagulation effects when combined with Paxlovid** |
| **The following options should be discussed with a provider:** |
| **Apixaban for AFIB** |
| **If Apixaban cannot be safely interrupted or adjusted** | Do NOT take Paxlovid Avoid in patients on hemodialysis |
| **If patient is on 5mg BID**  | START Paxlovid **and** DECREASE the dose of Apixaban to 2.5mg BID. Continue for 8 days and then RESUME previous dosing of Apixaban |
| **If patient is on 2.5mg BID**  | **Option 1: Do not use Paxlovid**  |
| **Option 2:** **Choose an alternative anticoagulant**1. HOLD Apixaban for 12-24 hours and then start both Paxlovid and the alternative anticoagulant. (ex. Enoxaparin)
2. Patient will take Paxlovid for 5 days and continue the alternative anticoagulant for 8 days. Then STOP the alternative anticoagulant and RESUME previous dose of Apixaban.
 |
| **Option 3:** **HOLD anticoagulation** 1. Have the patient HOLD Apixaban for 24 hours **before** starting Paxlovid **AND** Continue to HOLD for 8 days (total of 9 days) 2. Because of the prolonged time off of anticoagulation, this option should only be **reserved for those at very low thromboembolic risk.**   Please be aware that having an active COVID-19 infection may increase the baseline risk of having an embolic event and this should be taken into consideration |
| **Apixaban for VTE** |
| **The following options should be discussed with a provider:** |
| **If Apixaban cannot be safely interrupted or adjusted** | Do NOT take Paxlovid Avoid in patients on hemodialysis |
| **If patient is on 10mg BID**  | 1. START Paxlovid and DECREASE the dose of Apixaban to 5mg
2. Then consult anticoag for help with dosing for the duration of the 8 days.
 |
| **If patient is on 5mg BID** | 1. START Paxlovid and DECREASE the dose of Apixaban to 2.5mg BID
2. Continue for 8 days and then RESUME previous dosing of Apixaban
 |
| **If patient is on 2.5mg BID for VTE Extended Prophylaxis** | When starting Paxlovid, it is ok to continue current dosing, 2.5mg BID **Note:** because of the interaction with ritonovir, the patient will likely achieve therapeutic levels of anticoagulation for the 8 days |

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| **Rivaroxaban: Increased anticoagulation effects when combined with Paxlovid** |
| The ritonavir component of Paxlovid can increase the concentration of Rivaroxaban by 153%. **The following options should be discussed with a provider:** |
| **If Rivaroxaban cannot be safely interrupted or switched to an alternative anticoagulant**  | Do NOT take Paxlovid |
| **Choose an alternative anticoagulant** | 1. HOLD Rivaroxaban for 24-36 hours and then start both Paxlovid and the alternative anticoagulant. (ex. Enoxaparin, or half dose Apixaban).
2. Patient will take Paxlovid for 5 days and continue the alternative anticoagulant for 8 days.
3. Then STOP the alternative anticoagulant and RESUME previous dose of Rivaroxaban.
 |
| **HOLD anticoagulation** | 1. HOLD Rivaroxaban for 24 hours before starting Paxlovid
2. Start Paxlovid and continue to HOLD for 8 days (total of 9 days)

Because of the prolonged time off of anticoagulation, this option **should only be used if the patient has a LOW thromboembolic risk.****Low thromboembolic risk:** CHADSVasc < 3 and/or no hx of stroke, VTE more 1 year prior, no history of recurrent clots, no history of severe thrombophelia (APLS, homozygous factor V leiden, etc)Please be aware that having an active COVID-19 infection may increase the baseline risk of having an embolic event and this should be taken into consideration when discussing risk vs benefit with your patient. |

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| **Edoxaban: Possible increased anticoagulation effects when combined with Paxlovid** |
| **The following options should be discussed with a provider:** |
| **If Edoxaban cannot be safely interrupted or adjusted** | Do NOT take Paxlovid  |
| **Dose reduce Edoxaban by 50%** | 1. If patient is on Edoxaban **60mg Daily** DECREASE Edoxaban dose by 50% for a total of 8 days from the start of Paxlovid
2. RESUME the full dose of Edoxaban

**Note:** Recommendations are limited for patients on Edoxaban 30mg Daily * May consider switching to an alternative anticoagulant like (ex. Lovenox) or holding Edoxaban (See below)
 |
| **Choose an Alternative Anticoagulant** | 1. HOLD Edoxaban for 24 hours and then start both Paxlovid and the alternative anticoagulant. (ex. Enoxaparin)
2. Patient will take Paxlovid for 5 days and continue the alternative anticoagulant for 8 days.
3. Then STOP the alternative anticoagulant and RESUME previous dose of Edoxaban.
 |
| **HOLD Anticoagulation** | 1. HOLD Edoxaban for 24 hours before starting Paxlovid
2. Start Paxlovid and continue to HOLD for 8 more days (total of 9 days)

Because of the prolonged time off of anticoagulation, this option **should only be used if the patient has a LOW thromboembolic risk.****Low thromboembolic risk:** CHADSVasc < 3 and/or NO history of stroke, VTE greater than 1 year prior, NO history of recurrent clots, NO history of severe thrombophelia (NO APLS, NO homozygous factor V leiden, etc)Please be aware that having an active COVID-19 infection may increase the baseline risk of having an embolic event and this should be taken into consideration when discussing risk vs benefit with your patient. |

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| **Dabigatran:****Possible increased anticoagulation effects when combined with Paxlovid** |
| **The following options should be discussed with a provider:** |
| **If Dabigatran cannot be safely continued, interrupted or adjusted** | Do NOT take Paxlovid |
| **Dabigatran for AFIB** |
| CrCl > 50mL/min Reduced Dose Dabigatran | 1. Recommendation is to DECREASE dose to 110mg BID for 8 days when starting Paxlovid\*\*

**Note:** The 110 dose is NOT APPROVED for treatment of atrial fibrillation in the United States and this dose may not be covered by insurance  |
| CrCl 30-50mL/min Reduced Dose Dabigatran | 1. DECREASE dose of Dabigatran to 75mg BID and continue for 8 days\*\*
2. Resume previous dose of Dabigatran on day 9
 |
| CrCl < 30mL/minDo NOT Combine | Do NOT take Paxlovid with Dabigatran\*\* |
| \*\* | May consider switching to an alternative anticoagulant like (ex. Lovenox) or holding Dabigatran (See below) |
| **Dabigatran for VTE** |
| **Combined use with Dabigatran 150mg BID is not recommended**May consider switching to an alternative anticoagulant or holding Dabigatran  |
| **Choose an alternative anticoagulant** | 1. HOLD Dabigatran for 12-24 hours and then start both Paxlovid and the alternative anticoagulant. (ex. Enoxaparin)
2. Patient will take Paxlovid for 5 days and continue the alternative anticoagulant for 8 days.
3. STOP the alternative anticoagulant and RESUME previous dose of Dabigatran.
 |
| **HOLD Anticoagulation** | 1. HOLD Dabigatran for 12-24 hours and START Paxlovid
2. Continue to HOLD Dabigatran for 8 more days (total of 9 days) and then RESUME previous dose of Dabigatran

Because of the prolonged time off of anticoagulation, this option **should only be used if the patient has a LOW thromboembolic risk.****Low thromboembolic risk:** CHADSVasc < 3 and/or NO history of stroke, VTE greater than 1 year prior, NO history of recurrent clots, NO history of severe thrombophelia (NO APLS, NO homozygous factor V leiden, etc)Please be aware that having an active COVID-19 infection may increase the baseline risk of having an embolic event and this should be taken into consideration when discussing risk vs benefit with your patient. |

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| **Warfarin:****Possible increased or decreased anticoagulation effects when combined with Paxlovid** |
| Ok to take with Paxlovid but INR should be closely monitored due to potential increase and decrease in INR. Patients should contact their anticoagulation clinic to arrange for an INR check soon after taking Paxlovid. *INR testing may be difficult when patients have COVID.* |
| **Enoxaparin:****No change in anticoagulation effect expected when combined with Paxlovid** |
| No interaction expected with Paxlovid. Should be okay to take with Paxlovid (but this is based on limited evidence) |

Recommendations for how to manage drug interactions between Paxlovid and the various anticoagulants comes from the Liverpool COVID-19 Drug-Drug Interaction website.

The recommendations in this guide are meant to serve as treatment guidelines for BILH. These guidelines should not replace a provider’s professional medical advice based on clinical judgment.

Be aware, research is actively ongoing in this space and practice guidelines may from time to time change. The authors of these guidelines have made all attempts to ensure the accuracy based on current information based on the last date of revision. Users of these guidelines are strongly encouraged to confirm the information contained within them through an independent source.

Revised:

5/27/2022 - Sent to BILH