ANTICOAGULANT DOSING CONVERSIONS

Conversion of DABIGATRAN ETEXILATE

Switching from DABIGATRAN to WARFARIN

- Adjust starting time of warfarin based on CrCl as follows:
  - CrCl ≥50mL/min: Start warfarin **3 days** before discontinuing dabigatran
  - CrCl 30–50mL/min: Start warfarin **2 days** before discontinuing dabigatran
  - CrCl 15–30mL/min: Start warfarin **1 day** before discontinuing dabigatran
  - CrCl <15mL/min: No recommendations can be made
- Since dabigatran can increase INR, the INR will better reflect warfarin's effect only after dabigatran has been stopped for at least 2 days

Switching from DABIGATRAN to PARENTERAL ANTICOAGULANT

- Currently receiving dabigatran:
  - Wait **12hrs (CrCl ≥30mL/min)** or **24hrs (CrCl <30mL/min)** after the last dose of dabigatran before initiating treatment with a parenteral anticoagulant

Conversion of APIXABAN

Switching from APIXABAN to WARFARIN

- Apixiban affects INR levels, so the INR measurement during co-administration with warfarin may not be useful for determining the appropriate dose of warfarin
  - Discontinue apixaban and start both a parenteral anticoagulant and warfarin at the time the next dose of apixaban would have been taken, then discontinue the parenteral anticoagulant when INR reaches an acceptable range

Switching between APIXABAN and ANTICOAGULANTS other than WARFARIN

- Discontinue one being taken and begin the other at the next scheduled dose

Conversion of RIVAROXABAN

Switching from RIVAROXABAN to WARFARIN

- Rivaroxaban affects INR levels, so INR measurements during co-administration with warfarin may not be useful for determining the appropriate dose of warfarin
  - Discontinue rivaroxaban and start both a parenteral anticoagulant and warfarin at the time the next dose of rivaroxaban would have been taken

Switching from RIVAROXABAN to ANTICOAGULANTS other than WARFARIN

- Currently taking rivaroxaban and transitioning to an anticoagulant with rapid onset:
  - Discontinue rivaroxaban and give 1st dose of the other anticoagulant (oral or parenteral) at the time the next dose of rivaroxaban would have been taken

Switching from ANTICOAGULANTS other than WARFARIN to RIVAROXABAN

- Currently receiving an anticoagulant other than warfarin:
  - Start rivaroxaban 0–2hrs prior to the next scheduled evening dose of the drug (eg, low molecular weight heparin or non-warfarin oral anticoagulant) and omit administration of the other anticoagulant
  - Start rivaroxaban at the same time a continuous infusion of unfractionated heparin is discontinued

Conversion of HEPARIN

Switching from HEPARIN to WARFARIN

- Dose warfarin with the usual initial amount (eg, 2–5mg PO or IV daily) and determine PT/INR at the usual intervals
- Overlap warfarin with full dose heparin therapy for 4–5 days until warfarin has produced the desired therapeutic response as determined by PT/INR. Heparin may be discontinued at that time without tapering.
- The interference with heparin anticoagulation is of minimal clinical significance during initial therapy with warfarin
- Patients receiving both heparin and warfarin should have blood for PT/INR determination drawn at least:
  - 5hrs after the last IV bolus dose of heparin, *or*
  - 4hrs after cessation of a continuous IV infusion of heparin, *or*
  - 24hrs after the last subcutaneous heparin injection

Switching from HEPARIN/PARENTERAL ANTICOAGULANT to DABIGATRAN

- Currently receiving a parenteral anticoagulant:
  - Start dabigatran 0–2hrs before the next scheduled dose of the parenteral drug would have been given, *or*
  - Start dabigatran at the time of discontinuation of a continuously administered parenteral drug (eg, IV unfractionated heparin)

Conversion of WARFARIN

Switching from WARFARIN to DABIGATRAN

- Discontinue warfarin and start dabigatran when **INR** is **<2.0**

Switching from WARFARIN to APIXABAN

- Discontinue warfarin and start apixaban when **INR** is **<2.0**

Switching from WARFARIN to RIVAROXABAN

- Discontinue warfarin and start rivaroxaban as soon as **INR** is **<3.0** to avoid periods of inadequate anticoagulation

NOTES

Please see drug monograph at www.eMPR.com and/or contact company for full drug labeling.

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