Implementation Guidance for Reviewing Switching of Patients from Warfarin to a Direct Oral Anticoagulant (DOAC) during the coronavirus pandemic

Introduction

- Switching appropriate patients from warfarin to a DOAC may be considered to avoid regular blood tests for INR monitoring and reduce footfall in GP surgeries and pathology departments

- NHS England and NHS Improvement have released guidance for the management of anticoagulant services during the coronavirus pandemic. Appendix 1 gives guidance on reviewing and switching patients from warfarin to DOACs. Click here for further information

Key points when implementing guidance

- It is important not to carry out a blanket switching of patients, in order to protect the supply chain of DOACs. Reviewing and switching patients should be carried out in a phased approach over the cycle of INR monitoring.
  Consider prioritising:
  - Patients with poor control of INR (if not adherence related) – they require frequent INR checks
  - Patients who are Shielding and have been advised to stay at home for 12 weeks
  - Patients who are housebound and require a district nurse to take their blood for INR testing

- Not all patients on warfarin are appropriate to switch to a DOAC. See the switching decision aid flow chart in this guide (see below) to help identify appropriate patients – note it is not appropriate to switch patients to a DOAC if they have a history of non-adherence or other reasons which might lead to missed doses. Unlike with warfarin, non-adherence/missed doses are not able to be monitored through blood levels while taking a DOAC and the patient would be at an increased risk of having a thromboembolic event.

- When deciding to switch a patient to a DOAC, review any medications that they are prescribed and any medical conditions which increase the risk of bleeding e.g. NSAIDs, SSRIs and herbal medications. Where appropriate:
  - Consider changing to an alternative agent (e.g. a shorter acting NSAID)
  - Consider prescribing a proton pump inhibitor (PPI) to reduce the risks
  - Consider prescribing a DOAC that has a lower GI bleed incidence – apixaban or edoxaban

- The following patient details will be required to aid the choice of DOAC and dosing:
  - Age
  - Weight – Please note patients at extremes of body weight (<50kg or >120kg) should remain on warfarin
  - Renal function (within last 3 months) – this needs to be calculated as creatinine clearance (CrCl) using actual bodyweight, a creatinine clearance (CrCl) calculator can be found here – note dabigatran is contraindicated when CrCl<30ml/min
  - Indication for anticoagulation
  - Other medications the patient takes (prescribed, over the counter and herbal/vitamins) – the table in Appendix 1 of the national guidance lists significant interactions with the different DOAC agents

  Use the table in Appendix 1 of the national guidance, in combination with the manufacturers' Summary of Product Characteristics (SPC) to determine which DOAC agents are clinically appropriate for the patient. A national procurement arrangement has secured preferential pricing for apixaban and rivaroxaban. Therefore, **where either**

apixaban or rivaroxaban are clinically appropriate then patients should be changed to one of these agents. Where both apixaban and rivaroxaban are appropriate, 80% of patients should be switched to apixaban and 20% to rivaroxaban.

- When advising on switching a recent, reliable INR result is required. Advice on when to stop warfarin and start the DOAC can be found in Appendix 1 of the national guidance. This advice is a pragmatic approach to minimize the risks of bleeding and clotting and the need for additional INR tests.

- Use the DOAC counselling checklist included in Appendix 1 of the national guidance to ensure the patient is fully informed regarding their new medication. The patient must be clearly counselled on when to stop taking warfarin and when to start the DOAC to reduce the risks of bleeding or clotting during switching.

- **Ensure the patient's Anticoagulation Monitoring Service (AMS) are informed that they are no longer taking warfarin.**

- Monitoring:
  FBC & LFTs should be reviewed annually
  Review renal function – CrCl >60ml/min – annually
  CrCl 30-60ml/min and/or aged >75years and/or frail – 6 monthly
  CrCl 15-30ml/min – 3 monthly

Useful links

Manufacturers Summary of Product Characteristics - https://www.medicines.org.uk/

Patient alert cards and leaflets:

Apixaban: Alert card
Patient information booklet

Dabigatran: Alert card
Patient information booklet

Edoxaban: Alert card
Patient information booklet

Rivaroxaban: Alert card
Patient information booklet

National Guidance

NHS England and NHS Improvement Clinical guide for the management of anticoagulant services during the coronavirus pandemic

Local CCG guidance:

Ipswich and East Suffolk CCG

- Guidance on use of DOACs and warfarin in non-valvular Atrial Fibrillation

North East Essex CCG

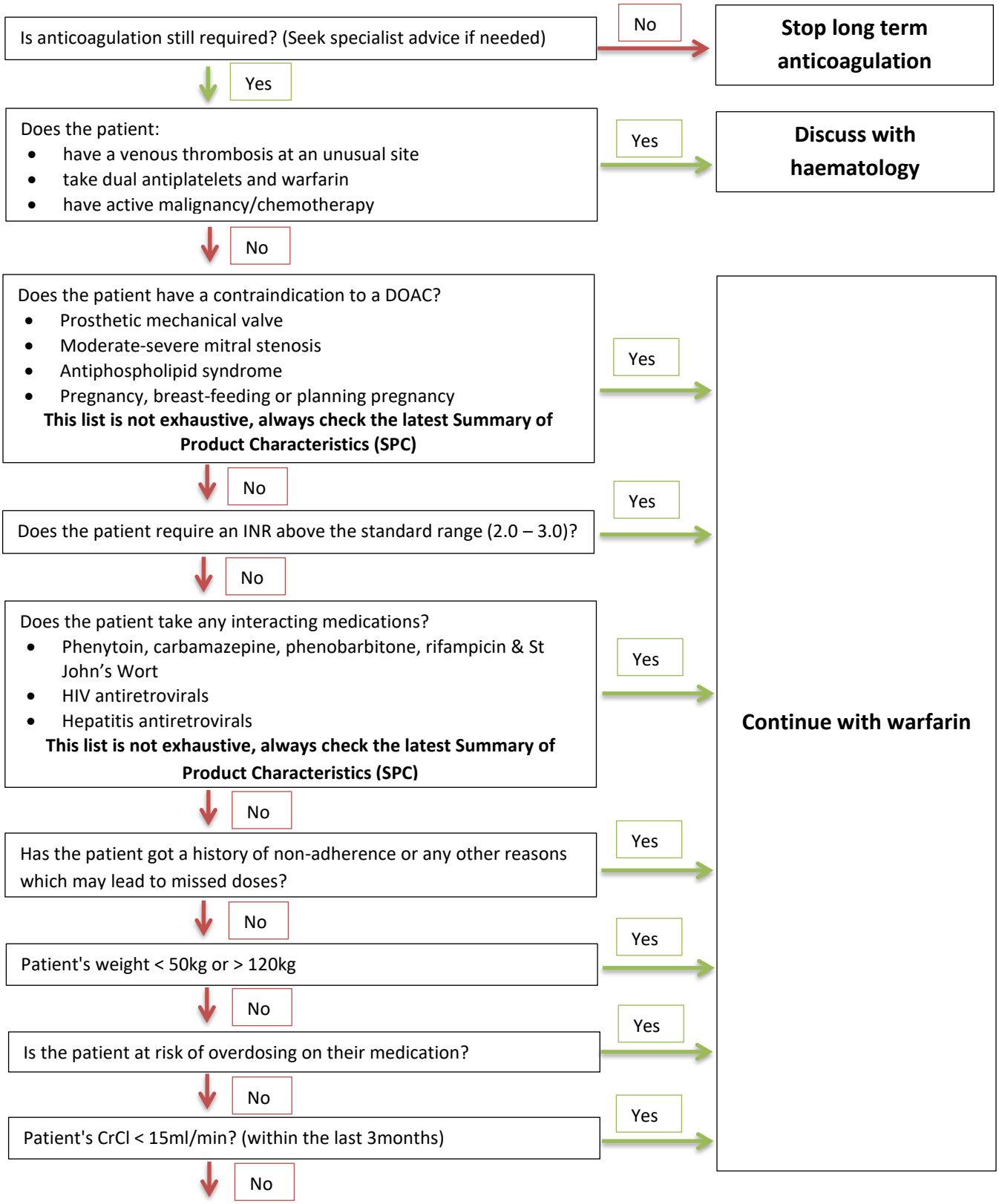
- Atrial Fibrillation anticoagulation clinical decision aid

West Suffolk CCG

- Atrial Fibrillation Anticoagulation Guidance (under '**Further Policies and Guidelines**')
- Switching from Warfarin to a DOAC: Available Support from the WSFT Anticoagulation Monitoring Service (under '**Covid-19 - Guidance**')

Jointly approved by Ipswich and East Suffolk CCG, North East Essex CCG and West Suffolk CCG

Warfarin to DOAC Switching Decision Aid Flowchart



Change to a DOAC using the most recent INR result

- **Apixaban**
- **Rivaroxaban**
- **Dabigatran**
- **Edoxaban**

See the table in Appendix 1 of national guidance for advice on agents to help identify clinically appropriate DOACs.
Choose apixaban or rivaroxaban in preference if possible as these are the cost-effective options

Produced by the Medicines Management Team, Ipswich and East Suffolk CCG in collaboration with North East Essex CCG, West Suffolk CCG, WSFT and ESNEFT. Final Version 1.0. June 2020. Review December 2020.