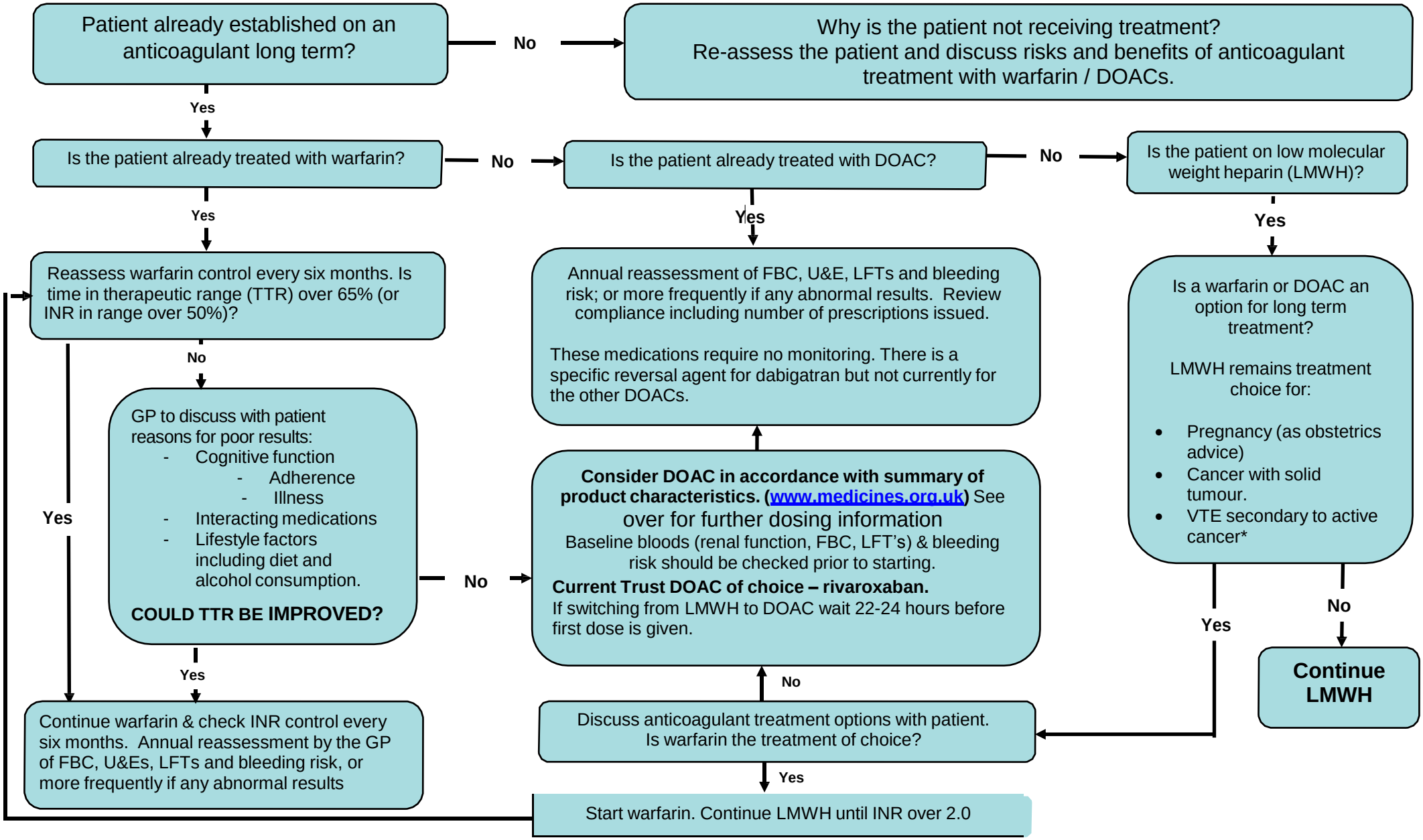
NHS Vale of York Clinical Commissioning Group

York Teaching Hospital NHS NHS Foundation Trust

Long Term VTE prevention anticoagulant treatment pathway



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DOAC DOSING RECOMMENDATIONS FOR NEW DVT/PE: Experience with DOACs is currently limited to short term use

RENAL FUNCTION	APIXABAN DOSE	DABIGATRAN DOSE	EDOXABAN DOSE	RIVAROXABAN DOSE
Normal or mild renal impairment Creatinine clearance >50 mL/minute	10mg twice daily for 1 week then 5mg twice daily for 3 months then review If for long term treatment for prevention of VTE, continue 5mg twice daily for six months in total, then use maintenance dose 2.5mg twice daily.	LMWH alone for at least the first 5 days then 150mg twice daily for 3 months then review For patients aged over 80, or on verapamil the recommended dose is 110mg BD. For patients aged between 75 -80, those with gastritis or GORD or at increased risk of bleeding consider 110mg BD **However, for VTE the recommendation for 110 mg BD is based on pharmacokinetic and pharmacodynamic analyses and has not been studied in this clinical setting.	LMWH alone for at least the first 5 days then 60mg ONCE daily for at least 3 months then review. Dose should be reduced to 30mg once daily with one of more of the following: • CrCl 15- 50mL/min • Body weight under 60kg • Concomitant use of P-glycoprotein (P-gp) inhibitors: ciclosporin, dronedarone, erythromycin, or ketoconazole.	Initial loading dose 15 mg twice daily with food for 3 weeks then 20 mg once daily with food for 3 months then review. Consider dose reduction to 10mg daily after 6 months
Moderate to severe renal impairment Creatinine clearance 15-49mL/minute	Dose as above, but use with caution. Limited clinical data indicate that apixaban plasma concentrations are increased in patients with severe renal impairment (creatinine clearance 15-29 mL/min) which may lead to an increased bleeding risk.	CrCl 30 – 49mL/min: The recommended dose is 150 mg capsule twice daily. However, for patients with high risk of bleeding, a dose reduction to 110 mg twice daily should be considered. Close clinical surveillance is recommended in patients with renal impairment. See** above Contraindicated if CrCl is < 30mL/min	CrCl 15 -50 mL/min dose reduced to 30mg once daily	Dose as above but use with caution. A reduction of dose to 15mg once daily following initial loading dose should be considered if assessed risk of bleeding outweighs risk of recurrent DVT and PE. Limited clinical data indicate that plasma concentrations are significantly increased for patients with severe renal impairment (CrCl 15-29mL/min)
CrCl <15 mL/minute	Not recommended	Contraindicated if CrCl is < 30mL/min	Not recommended	Not recommended

DVT/PE DOSING RECOMMENDATIONS FOR PATIENTS WITH POOR WARFARIN CONTROL SWITCHING TO DOAC

Stop warfarin and check the INR. Rivaroxaban and edoxaban can be started once the INR is 2.5 or under. Apixaban and dabigatran can be started when the INR is under 2.0. If the patient has been treated with warfarin or parenteral anticoagulation for more than the initial loading dose period of DOAC the patient can be started directly on the maintainance dose. If a patient is switching to apixaban for prevention of further VTE and they have already had six months treatment, they can be switched directly on to 2.5mg BD

***EXTENDED TREATMENT OF DALTEPARIN IN PATIENTS WITH SOLID TUMOURS (GFR>30mL/min)**

Dalteparin & tinzaparin are both licensed for extended treatment of VTE and prevention of its recurrence in patients with solid tumours. However, British Committee for Standards in Haematology recommends LMWH for all patients with cancer associated VTE. http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2141.2011.08753.x/full

Patient Weight	Dalteparin dose (units) ONCE daily for 1 month	Then dose (units) ONCE daily from month 2 onwards
40-45kg	7500 units	7500 units
46-56kg	10,000 units	7500 units
57-68kg	12,500 units	10,000 units
69-82kg	15,000 units	12,500 units
83-98kg	18,000 units	15,000 units
99kg and greater	18,000 units	18,000 units

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