Top Tips for Clinicians

DOAC prescribing in AF and DVT/PE
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Disclaimer: These are intended only as good practice prompts. Use your clinical judgement.

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Top Tip 1

DOACs/NOACs (Direct/Novel Oral Anti-Coagulants) used in AF:

- Rivaroxaban
- Dabigatran
- Apixaban
- Edoxaban

Review of records suggests 11% of hospital discharge summaries and 25% of GP DOAC prescriptions are for incorrect dosages; so patients will either be at increased risk of bleeding or not protected from stroke!

Dosing is based on **renal function, which may change and requires monitoring.** Check Creatinine Clearance (CrCl), **NOT** eGFR (easily calculated in S1 by using the "Renal Disease Calculations" in Clinical Tools) Use your opportunities to check the dosing at:

1. Commencement by hospital teams (discharge summary or out-patient clinic)
2. GP yearly medication review

Top Tip 2

Each DOAC has different rules for dosage adjustment in CKD (ref chart in appendices):

- Dabigatran is contraindicated in CrCl <30ml/min
- Reduce dose of Rivaroxaban (and Edoxaban) at CrCl <50 ml/min
- Apixaban is more forgiving and so reduced if CrCl <30 ml/min

Apixaban also requires weight & age. Reduce dose of Apixaban to 2.5mg BD if ≥ two:

- Age ≥80
- Weight ≤60kg
- Creatinine ≥133 µmol/L

All DOACs are contraindicated in CrCl <15ml/min when warfarin is the anticoagulant of choice

Top Tip 3

DOACs are not "fire & forget" medicines! They do not require INRs but they DO require periodic blood tests. If the renal function changes, the dose may need changing (see Tip 2)

1. Everyone should have yearly FBC U&E LFT
2. If renal function is impaired CrCl<60 or age >75 or borderline result:
   a. Age >75 check U&Es every 6 months
   b. CrCl 30-60 check U&Es every 3-6 months
   c. CrCl 15-30 check U&Es every 3 months

Top Tip 4

For **DVT / PE dosing** – it is different to AF. Locally, mainly Rivaroxaban (and Apixaban) are used.

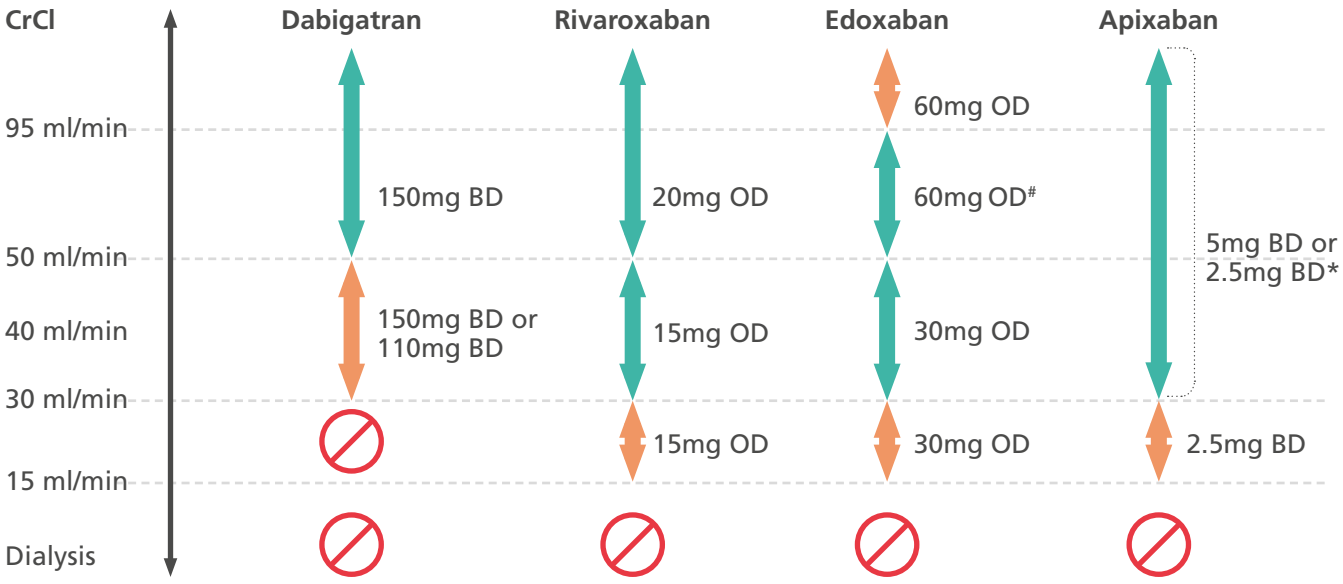
- Treat at full dose for 6 months if CrCl >30ml/min, but then dose may be reduced. If long term dosing beyond 6 months is not clear in specialist letters, seek specialist advice (via e-consult).

DOAC Top Tips

DOAC dosing for stroke prevention in patients with non-valvular Atrial Fibrillation according to renal function

CrCl ≥50ml/min	Rivaroxaban 20mg OD	Apixaban 5mg BD*	Edoxaban 60mg OD#	Dabigatran 150mg or 110mg BD
CrCl 30-49ml/min	Rivaroxaban 15mg OD	Apixaban 5mg BD*	Edoxaban 30mg OD	Dabigatran 150mg BD or Consider using 110mg BD if high bleeding risk
CrCl 16-29ml/min	Rivaroxaban 15mg OD	Apixaban 2.5mg BD	Edoxaban 30mg OD	Dabigatran contraindicated
CrCl ≤15ml/min	All DOACs contra-indicated			

* Patients with ≥2 of the following should receive 2.5mg BD dose of Apixaban
• Age ≥80 • Weight ≤60kg • Serum Creatinine ≥133umol/L (1.5mg/dl)
If patient weight <60kg Edoxaban dose should be reduced to 30mg OD



Dosing advice for Apixaban and Rivaroxaban for DVT/PE

	Apixaban	Rivaroxaban
Standard Dose If CrCl >30ml/min	Days 1-7: 10mg BD Days 8 onwards: 5mg BD After 6 months: 2.5mg BD	Days 1-21: 15mg BD with food Day 22 onwards: 20mg OD with food After 6 months: 10mg OD
Renal Impairment Warfarin preferred if CrCl 15-30ml/min DOACs contra-indicated if CrCl <15ml/min	Do not use if CrCl less than 15ml/min	Do not use if CrCl less than 15ml/min
		Day 22 onwards if CrCl 30-49ml/min; consider reducing to 15mg OD if the patient's risk of bleeding outweighs the risk of recurrence

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