Nottingham and Nottinghamshire
Clinical Commissioning Group

Medicines Management FAQs

Switching Patients from Warfarin to DOACs due to current COVID–19 Situation

Please note we are not currently suggesting switching patients on a large scale from warfarin to a DOAC.
However, switching may be considered as a measure to protect vulnerable patients and reduce the need for blood tests during the COVID outbreak.

Note that DOACs are not a suitable alternative for certain patients and we have had reports of patients being asked to switch inappropriately, e.g. a dialysis patient.
Switching should only be considered on an individual patient by patient basis.

Locally, **edoxaban is the first line DOAC for patients with NVAF** unless there is a specific clinical reason to use a different DOAC. We have received assurance from the manufacturers of edoxaban that they have sufficient stock to cope with the potential increase in demand during the pandemic.

NHSE have secured a temporary price reduction for rivaroxaban and apixaban during COVID19, the long term cost impact has been assessed and we have concluded that the current recommendation still stands i.e. **edoxaban remains the first line DOAC** for patients with NVAF unless there is a specific clinical reason to use a different DOAC. Both apixban and rivaroxaban can still be used where appropriate, as per the APC Anticoagulants in AF Guideline and APC DOACs for DVT and PE Guideline.

National Guidance:
National guidance (endorsed by Royal College of General Practitioners & British Haematology Society) is now available (here), which complements our local guidance and has some practical advice on how to switch patients. It was launched with the following statement:

'*A number of associations and societies across the UK have come together to provide guidance on the safe switching of warfarin to DOACs This needs to be undertaken in a phased manner over the 12 week cycle of INR monitoring to protect the supply chain for ALL patients. As highlighted, many patients are not suitable for a switch from warfarin to DOACs and further guidance will be available shortly to support services providing care for these patients.*'

MHRA (13/10/20): Warfarin and other anticoagulants – monitoring of patients during the COVID-19 pandemic
Some patients taking warfarin may have been switched to DOACs during the pandemic to avoid regular blood tests for INR monitoring. Healthcare professionals will be aware that VKA interact with a large number of medicines but are also reminded that direct-acting oral anticoagulants (DOACs) including Eliquis (apixaban), Lixiana (edoxaban), Pradaxa (dabigatran) or Xarelto (rivaroxaban) also interact with several medicines.

Local Guidance:
Local haematologists have raised concern about mass switching from warfarin to DOACs due to concerns that patients may be switched inappropriately and put at risk of complications. However, they do understand that there may be a need to do this, particularly in those patients deemed to be at high risk and isolating at home, or those in self-isolation due to symptoms or symptomatic member of household. Ideally before switching patients, this should be discussed with the haematology service, especially for complex patients. However please note that the service may have limited capacity to respond at present.

All DOACs are licensed for the prevention of atrial fibrillation (AF)-related stroke in people with non-valvular AF and for the treatment and secondary prevention of deep vein thrombosis (DVT) and pulmonary embolism (PE).

Written by Medicines Optimisation Team with input from NUH Haematology service
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The following advice from the CCG medicines optimisation team, with input from the NUH haematology service, should be considered if thinking about switching to a DOAC:

- DOACs are not a suitable alternative for certain patients on warfarin. If any of the following criteria apply patients **CANNOT be switched to a DOAC**:
    - Weight <50 or >150kg
    - Creatinine clearance <15ml/min
    - On any of the following drugs: carbamazepine, enzalutamide, phenytoin, phenobarbital, primidone, rifampicin, ketoconazole, itraconazole, posaconazole, HIV protease inhibitors e.g. ritonavir, telaprevir (list not exhaustive check if unsure). See here for more information.
    - Pregnant or breastfeeding, or planning a pregnancy
    - Children
    - Moderate to severe valve disease
    - INR range higher than 2-3 (or if pt has Medway alert to have enoxaparin if INR below range)
    - Mitral stenosis
    - IVC filter
    - Prosthetic Mechanical heart valve
    - Moderate to severe valvular AF
    - Non licensed indications e.g LV thrombus, arterial thrombus, VTE at unusual site (e.g. venous sinus thrombus, hepatic portal vein)
    - Antiphospholipid syndrome
    - Hepatic disease associated with coagulopathy and clinically relevant bleeding risk including cirrhotic patients with Child Pugh B and C
    - Active malignancy/chemotherapy (unless advised by a specialist)
    - On triple therapy (dual antiplatelet plus warfarin), switching these patients should be discussed with an anticoagulant specialist or cardiologist.

- Before patients could switch from warfarin to a DOAC they would need an INR to make sure it was safe to switch according to the dosing guidelines in the SPC.
- If patients are stable on warfarin then switching may not be necessary but it may be possible to consider reducing the frequency of INR monitoring on a case-by-case basis.
- DOAC dosing is a function of indication, age, weight and renal function. It is complex and has been shown to be incorrect in up to 25% of patients, with a risk of bleeding/under-treatment.
- The measure of renal function is estimated creatinine clearance (CrCl) which relies on up-to-date weight and serum creatinine for calculation. Please ensure that patients have a recent weight for the calculation of serum creatinine.
- DOAC dosing needs to be reviewed regularly in the light of changing clinical circumstances https://www.sps.nhs.uk/articles/direct-acting-oral-anticoagulants-doacs-in-renal-impairment-practice-guide-to-dosing-issues/
- Self-testing for INR is only done in Nottinghamshire if patient has bought their own machine, GP supplies testing strips, and the patient is trained by NUH Anticoagulant Service (which includes quality control of their machine). At present, the service cannot manage a significant influx of patients for self-testing assessment/training, so this is not a viable option for primary care at the present time. It also has the potential to lead to a shortage of strips if demand suddenly rises.

Please also follow APC guidance on AF: prescriber decision support on anticoagulation.

For further information see NHSE and I Clinical guide for the management of anticoagulant services during the coronavirus pandemic