NHS
West Hampshire
Clinical Commissioning Group

Agreement for Safe Switching of Warfarin to Direct Oral Anticoagulants (DOACs) for Patients with Non-Valvular AF and Venous Thromboembolism (DVT / PE)

Practice name	

- *In response to pressures on the NHS, the way we deliver anticoagulants may need to change.*
- *We have a key role in continuing to keep patients on anticoagulants as safe as possible; this must be planned.*
- *We should seek the best local solutions to continue the safe management of patients on anticoagulation while protecting resources for the response to coronavirus.*
  NHSE&I Clinical guide for the management of anticoagulant services during the coronavirus pandemic

- This is an opportunity to review the need for anticoagulation in all patients on warfarin. Is it time to stop or consider an alternative method of treatment with DOACs?

- All proposed switches to DOACs should be compliant with recent national guidance for the safe switching of warfarin to direct oral anticoagulants (DOACs) for patients with non-valvular AF and venous thromboembolism (DVT / PE) during the coronavirus pandemic (RCGP and BHS endorsed)

- Patients should only be switched from warfarin to a DOAC by clinicians in primary or secondary care with experience in managing anticoagulation (hitherto referred to as 'Switching clinician').

- Switching clinician to review whether anticoagulation is still safe and appropriate for the patient (check for anaemia, bleeding risks).
- Assess whether anticoagulation can be safely stopped (e.g. in patients with prior DVT / PE, where risk of recurrence is now considered low).

- A switch from warfarin to a DOAC should not be considered for patients:
  - With a prosthetic mechanical valve
  - With moderate to severe mitral stenosis
  - With antiphospholipid antibody syndrome (APLS) – seek specialist haematology advice
  - Who are pregnant, breastfeeding or planning a pregnancy
  - Requiring a higher INR than the standard INR range of 2.0 – 3.0
  - With severe renal impairment - Creatinine Clearance (CrCl) < 15ml/min
  - With active malignancy/ chemotherapy (unless advised by a specialist)
  - Prescribed interacting drugs, especially
    - Some HIV antiretrovirals and hepatitis antivirals - check with HIV drug interactions website at https://www.hiv-druginteractions.org/
    - Some antiepileptics - phenytoin, carbamazepine, phenobarbitone or rifampicin (likely to reduce DOAC levels so discuss with an anticoagulation specialist)
  - On triple therapy (dual antiplatelet therapy plus warfarin) without discussing with an anticoagulant specialist or cardiologist
  - With venous thrombosis at unusual sites (e.g. portal vein thrombosis) - discuss with an anticoagulation specialist but there is now some evidence to support the use of DOACs (dabigatran may be best).

- Caution/ seek specialist advice for the following patients:
  - With thrombophilias e.g. Factor V Leiden thrombophilia who are being managed with warfarin range 2-3
  - With cardiomyopathy
  - With non-mechanical, prosthetic valves

PROCESS FOR SWITCHING FROM WARFARIN TO A DOAC IN GP PRACTICE		
STEP:	**DETAIL:**	**PERSON RESPONSIBLE:**
1.	Ensure local community pharmacies are made aware of the likely increase in the usage of DOACs. Ensure adequate supplies of anticoagulant cards to give out with first issue of DOAC. Ideally switches should be undertaken in a staged way rather than as a mass exercise, to safeguard stocks.	*PhP/ Practice Staff **PhP refers to Pharmacy Professional (MOT member or PCN pharmacist)*
2.	Produce lists of patients currently prescribed warfarin for Switching clinicians using GP clinical system searches provided	PhP/ Practice Staff
3.	Identify patients taking warfarin without a coding for Mechanical Heart Valves, Antiphospholipid Syndrome, or DOAC (NOAC) Contraindicated/ Not Indicated / Not Tolerated. Exclude other patients as above.	PhP/ Practice Staff
4.	Switching clinician to review list and indicate which patients might be suitable for a switch.	Switching clinician
5.	No changes should be made without a conversation with the patient. Contact patient/ carer to discuss proposed change. Use DOAC Counselling Checklist. Check hospital anticoagulation team have not already made the switch (anecdotal reports of this being duplicated). Ask patient/ carer for up-to-date weight.	PhP/ Switching clinician
5.	Check clinical system for recent FBC, U&Es, LFTs (within last 3 months)	PhP/ Switching clinician
6.	At next INR visit– check INR, record weight, take bloods if not already available or are unstable	Practice staff
7.	Calculate creatinine clearance (CrCl)	PhP/ Switching clinician
8.	Record suitability for switch to DOAC in patient record.	Switching clinician
9.	Choose DOAC drug and dose according to the therapeutic indication, patient age, actual bodyweight, renal function ‑ calculated Creatinine Clearance (CrCl), drug interactions and patient preference/lifestyle. As per NICE guidance, where more than one DOAC is available for the indication, the product with the lowest acquisition cost should be used. Note: WHCCG preferred formulary choice of DOAC for *stroke prevention in atrial fibrillation* is edoxaban unless there are clinical reasons for selecting an alternative. Prescribe DOAC at appropriate dose and advise patient to obtain supplies. Use DOAC Counselling Checklist and confirm details in Appendix I.	Switching clinician
10.	Advise patient when to stop warfarin in relation to starting DOAC (INR should be < 2.5 when DOAC is started) A pragmatic approach to stopping warfarin and starting DOAC in relation to the INR can be used according to EHRA advice: • If INR < 2: Commence DOAC that day • If INR between 2 and 2.5: Commence DOAC the next day (ideally) or the same day • If INR between 2.5 and 3: Withhold warfarin for 24-48 hours and then	PhP/ Switching clinician

	initiate DOAC Advise patient to put to one side (for subsequent disposal) any remaining stocks of warfarin to avoid duplicate dosing.	
11.	Use DOAC Counselling Checklist and confirm details in Appendices I & II	PhP/ Switching Clinician
12.	Provide written instructions and involve family members / carers where possible to minimise the risk of patients taking both warfarin and the DOAC concurrently. Particular care should be taken where patients are using medication compliance aids to minimise the risk of incorrect dosing.	PhP/ Switching clinician
13.	Safety-netting: Common and serious side-effects and who/when to refer: symptoms of bleeding/unexplained bruising. Avoidance of contact sports. • Single/self-terminating bleeding episode – routine appointment with GP/ pharmacist. Insert contact: ……. • Prolonged/ recurrent/ severe bleeding/ head injury – 999	PhP/ Switching clinician
14.	Provide an up-to-date Anticoagulant Alert card. Remove INR recall and yellow book from system. (anecdotal reports of switched patients still attending for automatic INR recall).	PhP/ Switching clinician
15.	Inform community nursing teams/ anticoagulation teams of the switch if they have been monitoring INR or administering warfarin. Inform the community pharmacy if the patient is a NOMAD patient so that it can be included in compliance aid (not dabigatran). Encourage New Medicine Service discussions with community pharmacist in future.	PhP/ Switching clinician
16.	Add patient to appropriate *routine* monitoring recall protocols. • Annual review (at least) of renal profile if CrCl > 60ml/min with FBC and LFTs • 6 monthly review if CrCl < 60ml/min and/or aged >75 years and/or frail • At lower end of the range (e.g. CrCl 15-30ml/min) ideally 3 monthly review of renal profile but may not be practical during Covid-19 pandemic. Check for side-effects/ bleeding issues and patient adherence to therapy at each routine appointment.	PhP / Practice staff
	OTHER PRACTICE-SPECIFIC REQUIREMENTS:	

Print Name & Role	**Signature**	**Date**
On behalf of practice:		
MOT member:		
MOT member:		

Appendices I & II Checklists

Appendix I: Patient-centred care: Switching Clinician to complete			
Confirm the following points have been discussed with and understood by the patient/ carer:			
Why DOAC prescribed (risk versus benefit)		How DOAC works	
Duration of treatment		Main side-effects	
Awareness of current availability of reversal agents		Risk of bleeding and action required in event of bleeding or a fall	
Need for at least annual blood tests if on long term (more frequent if weight or renal function changes as may require dose change)		Lifestyle considerations (e.g. contact sports)	
Not licensed in pregnancy (requires pregnancy test before starting)		Non hormonal contraception if treating VTE	

Appendix II Counselling Checklist: PhP / Anticoagulant Clinic to complete			
Dose checked		How to obtain repeat prescriptions	
Pregnancy (contraindicated) / periods (may get heavier)		Need for good compliance	
Check current medicines for interactions		Need for AT LEAST annual blood tests if on long-term	
Alcohol (is OK – no more than 2 units/day). No binge drinking		Drug interactions	
Missed doses		When to seek medical help (signs and symptoms of unusual or internal bleeding, falls/bang to head)	
The need to inform other healthcare professionals before any procedures		Provide indication specific info leaflet if available	
Side-effects (report to GP for review if troublesome)		Explain simple analgesia/NSAID/alternative therapies	
Stopping/ starting other medicines		Provide DOAC alert card	

References

https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Coronavirus/FINAL%20Guidance%20on%20safe%20switching%20of%20warfarin%20to%20DOAC%20COVID-19%20Mar%202020.pdf?ver=2020-03-26-180945-627