Direct Oral Anticoagulant Access During COVID-19

In response to the COVID-19 pandemic, the Drug Plan and Extended Benefits Branch is temporarily increasing access to direct oral anticoagulant (DOAC) medications for patients with atrial fibrillation, deep vein thrombosis or pulmonary embolism. As DOACs do not require routine coagulation testing, this will reduce the need for the ongoing INR monitoring which is required with warfarin. (See Saskatchewan Formulary Bulletin)

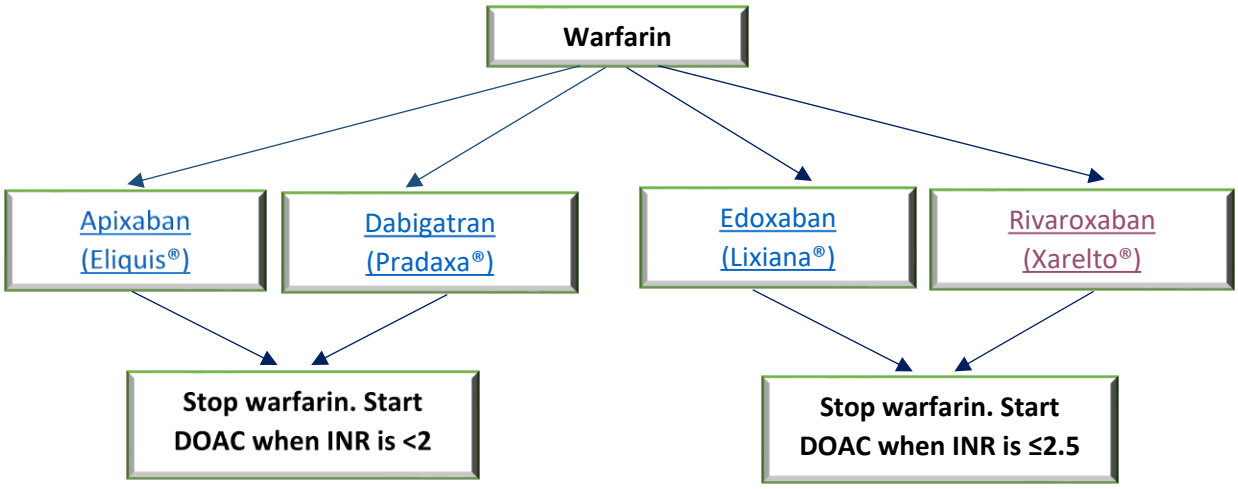
When a DOAC treatment is deemed therapeutically appropriate for atrial fibrillation, deep vein thrombosis or pulmonary embolism, full Formulary status will temporarily apply to:

- Apixaban (Eliquis®) 2.5mg, 5mg
- Dabigatran (Pradaxa®) 110mg, 150mg
- Edoxaban (Lixiana®) 15mg, 30mg, 60mg
- Rivaroxaban (Xarelto®) 15mg, 20mg – *excluding* 2.5mg or 10mg strengths which are used for alternate indications

It is important to consider patient factors (e.g. renal function, age, valvular heart disease, prosthetic heart valves, etc.) when determining the appropriateness of DOACs. For a helpful, drug specific *RxFiles* checklist to assist with determining if DOACs are an option for your patient, please click on the hyperlinked drug names below.

If a DOAC is **not** an option for your patient, point-of-care INR testing (Coaguchek XS™) may be an option ($$) if routine monitoring is unavailable.

Switching from Warfarin to a DOAC[1,2,3,4,5]



Switching from warfarin to a DOAC requires INR testing. The Roy Romanow Provincial Laboratory has confirmed that including "URGENT" on the lab requisition will ensure testing is completed.

General Monitoring Parameters for DOACs[1,2,3,4,5]

- CrCl at baseline and at least annually (more frequently with elderly patients, CrCl < 60 mL/min, declining renal function)
    - Apixaban, Rivaroxaban: may be considered when CrCl is > 15 mL/min
    - Dabigatran, Edoxaban: may be considered when CrCl is > 30 mL/min
- Liver function at baseline and at least annually
- Signs of bleeding

Transitioning Between DOACs[6]

Start the new DOAC when the next dose of the previous DOAC was scheduled to be given

Switching from a DOAC to Warfarin[5,6]

Dabigatran (Pradaxa®) to Warfarin:

-CrCl > 50 mL/min: start warfarin 3 days before discontinuing dabigatran

-CrCl 31-50 mL/min: start warfarin 2 days before discontinuing dabigatran

-CrCl 15-30 mL/min: start warfarin 1 day before discontinuing dabigatran

Rivaroxaban (Xarelto®) to Warfarin:

-Start warfarin. Stop rivaroxaban in 2-4 days and when INR ≥2

-Rivaroxaban can affect INR so checking INR just prior to next rivaroxaban dose may be more reflective of warfarin's anticoagulant effect

Apixaban (Eliquis®) to Warfarin:

-Start warfarin. Stop apixaban when INR >2

-Apixaban can affect INR so checking INR just prior to next apixaban dose may be more reflective of warfarin's anticoagulant effect

Edoxaban (Lixiana®) to Warfarin:

-Start warfarin, decrease edoxaban by ½ and discontinue edoxaban when INR >2

-Measure INR weekly, at minimum, and just prior to the daily dose of edoxaban to minimize the influence of edoxaban on INR

This is a general reference to supplement existing knowledge and is not intended to be a substitute for clinical judgement. Some patients on anticoagulation therapy have numerous comorbidities; for complex cases, it may be valuable to consult with the patient's specialist.

References:

1. Eliquis Product Monograph (Pfizer Canada Inc. Bristol-Myers Squibb Canada), Oct 7, 2019.
2. Pradaxa Product Monograph (Boehringer Ingelheim Canada), Mar 23, 2020.
3. Lixiana Product Monograph (Servier Canada Inc), Feb 12, 2020.
4. Xarelto Product Monograph (Bayer Inc), Sept 20, 2019.
5. RxFiles Drug Comparison Charts (12th Edition), Nov, 2019.
6. Lexicomp Online, Lexi-Drugs Online, Hudson, Ohio: Wolters Kluwer Clinical Drug Information, Inc., 2020.