NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Procedure for Switching Warfarin to Rivaroxaban in General Practice (within licensed indications) April 2020

1. **Search** for patients on Warfarin.
2. **Exclude** following patients: -
    a. Age <18 years (not licensed)
    b. Patients with antiphospholipid syndrome (APS)
    c. Patients who have hepatic disease associated with coagulopathy and clinically relevant bleeding risk, including people who have cirrhosis with Child-Pugh B (moderate impairment) or C (severe impairment).
    d. Valves replacement-bare metal or prosthesis, moderate to severe mitral stenosis, severe mitral regurgitation with a dilated left atrium
    e. Patient with valvular heart disease (see d above)
    f. Those who need INR >2.5
    g. Those on strong inhibitors of both CYP3A4 and P-gp i.e. azole-antimycotics (such as ketoconazole, itraconazole, voriconazole and posaconazole) or HIV protease inhibitors (e.g. ritonavir).
    h. VTE at unusual sites (e.g. cerebral vein thrombosis)
    i. Pregnancy and breastfeeding
3. **Exclude** those who have a recorded Creatinine Clearance (CrCl) less than 15ml/min - CONTRAINDICATED.

    For patients with renal impairment but CrCl is above 15ml/min switching can take place with CAUTION - patient will require monitoring every 3-6 months.
4. **Phone** patient to discuss switching
5. **Arrange appointment** for **renal and liver function tests, full blood count, weight and BP with HCA** and review with Clinician at the same visit.
6. **Clinical consultation including treatment counselling**- emphasis on compliance, use of PILs and Patient Decision making tool. Discuss side effects including dermatology (Steven Johnson Syndrome) Advise INR monitoring is not required with rivaroxaban (other monitoring will be required)
7. **Provide written instructions** to stop warfarin for 3 days before starting rivaroxaban.
8. **Prescribe correct dose** based on indication and current renal function (max 28 days per prescription)
9. **Send to pharmacy** electronically if possible
10. **Contact pharmacy directly for higher risk patients** i.e. those on a Dossett box.
11. **Inform local anticoagulation clinic** where INR is monitored / managed to prevent patient being called for further INR's.

    - Addenbrookes Anticoagulation Service: add-tr.anticoagulant@nhs.net
    - Peterborough City Hospital Anticoagulation Service :- nwangliaft.anticoagulationsvc@nhs.net
    - Hinchingbrooke Hospital Anticoagulation Service :- sue.jones43@nhs.net or jane.day8@nhs.net

NB. For patients registered with PCH for monitoring, the anticoagulation service will be sending patient lists to the GP practices which may help them prioritise transitioning and alert them to those that shouldn't be switched from warfarin to a DOAC.