Northwestern Medicine

November 2022

Direct Oral Anticoagulants (DOACs) Guide #1

	Pradaxa (dabigatran)	Eliquis (apixaban)	Xarelto (rivaroxaban)	Savaysa (edoxaban)	Coumadin (warfarin)
Approved Indications	- DVT/PE treatment and prevention of recurrence - VTE prevention post-hip replacement - Thromboembolism (e.g., stroke) prevention in nonvalvular AFib	- DVT/PE treatment and prevention of recurrence - VTE prevention post-hip or knee replacement - Thromboembolism (e.g., stroke) prevention in nonvalvular AFib	- DVT/PE treatment and prevention of recurrence - VTE prevention post-hip or knee replacement - Thromboembolism (e.g., stroke) prevention in nonvalvular AFib	- DVT/PE treatment and prevention of recurrence - Thromboembolism (e.g., stroke) prevention in nonvalvular Afib	- DVT/PE treatment and prevention of recurrence - Thromboembolism (e.g., stroke) prevention/tx due to A fib or prosthetic heart valve - Secondary Prevention Post-MI
MOA	**Direct thrombin inhibitor**	**Factor Xa inhibitor**	**Factor Xa inhibitor**	**Factor Xa inhibitor**	**Inhibits formation of vitamin-K dependent clotting factors**
Dosing	**Non-valvular AFib:** CrCl >30 mL/min: 150mg twice daily CrCl 15-30 mL/min: 75mg twice daily **DVT/PE treatment and prevention:** CrCl >30 mL/min: 150mg twice daily after 5-10 days of parenteral anticoagulation **DVT/PE prophylaxis:** 110mg for the first day, then 220mg once daily x 28-35 days (hip)	**Non-valvular A fib:** 5mg twice daily or 2.5mg twice daily in patients with ≥ 2 of the following: age ≥80 years, body weight ≤60 kg, or serum creatinine ≥1.5 mg/dL **Prophylaxis of DVT:** (first dose 12-24 hrs post-op) 2.5mg twice daily x 12 days (knee) or x 35 days (hip) **Treatment of DVT/PE:** 10mg twice daily x 7 days, then 5mg twice daily **Reduction in the Risk of Recurrent DVT/PE following initial therapy:** 2.5mg twice daily; following a minimum of 6 months of treatment for DVT or PE	**Non-valvular A fib:** CrCl >50mL/min: 20mg once daily with evening meal to improve absorption CrCl 15-50mL/min: 15mg daily with evening meal **Prophylaxis of DVT:** (first dose 6-10 hrs post-op) 10mg daily x 35 days (hip) **Treatment and Reduction in the Risk of Recurrence of DVT/PE:** 15mg twice daily x 21 days, then 20mg once daily [with food] for 6 months *Note: 15mg and 20mg doses must be taken with food; 10mg doses may be taken with or without food	**Non-valvular AFib:** CrCl >50-≤95mL/min: 60mg once daily CrCl ≤15 to 50mL/min: 30mg once daily **Do not use in CrCl >95mL/min in nonvalvular AFib as increased risk of stroke** **DVT/PE treatment:** Following 5-10 days of parenteral anticoagulation 60mg once daily; 30mg once daily if body weight ≤60kg	Adjusted based on INR

Resource: Comparison of Oral Anticoagulants. *Pharmacist's Letter.* 2019

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	Pradaxa (dabigatran)	Eliquis (apixaban)	Xarelto (rivaroxaban)	Savaysa (edoxaban)	Coumadin (warfarin)
Dosage Adjustments	No dosage adjustment needed for hepatic impairment **Non-valvular AFib:** Reduce dose for CrCl <30mL/min; No dosing information for CrCl <15mL/min **Prophylaxis of DVT/Tx of DVT/PE:** No dosing information if CrCl <30mL/min	Avoid in patients with severe (Child-Pugh C) hepatic impairment No dose adjustment is required when used for prophylaxis of DVT or treatment of DVT/PE and reduction in risk of recurrent DVT/PE Combined P-glycoprotein and strong CYP3A4 inhibitor decrease dose by 50% for patients on greater than 2.5mg twice daily. Avoid if already on 2.5mg twice daily **CYP3A4 inhibitor (eg, ketoconazole, itraconazole, ritonavir)**	Avoid in patients with moderate (Child-Pugh B) and severe (Child-Pugh C) hepatic impairment or any degree of hepatic disease associated with coagulopathy **Non-valvular AFib:** Reduce dose for CrCl <50mL/min; Avoid use if CrCl <15mL/min **Prophylaxis of DVT/Tx of DVT/PE:** Avoid use if CrCl <30mL/min	Avoid in patients with moderate (Child-Pugh B) and severe (Child-Pugh C) hepatic impairment Body weight 60kg or less in DVT or pulmonary embolism: 30mg once daily **Non-valvular AFib:** Reduce dose for CrCl <50mL/min; Avoid use if CrCl <15mL/min **Do not use in CrCl >95mL/min in nonvalvular AFib as increased risk of stroke.** **Prophylaxis of DVT/Tx of DVT/PE:** Reduce dose for CrCl <50mL/min; Avoid use if CrCl <15mL/min	Use cautiously in patients with hepatic impairment No dosage adjustment is necessary for patients with renal impairment Geriatric: consider lower initial and maintenance dose
Reversal Strategies	**Praxbind** (idarucizumab)	**Andexxa** (andexanet alpha)			Vitamin K, **Kcentra** (prothrombin complex concentrate)
Dialyzable	~60%	No	No	No	
Warfarin to DOAC	Discontinue warfarin, start when INR <2		Discontinue warfarin, start when INR <3	Discontinue warfarin, start when INR is ≤ 2.5	