Conversion of **DABIGATRAN ETEXILATE**

**Switching from DABIGATRAN to WARFARIN**

- Adjust starting time of warfarin based on CrCl as follows:
  - CrCl ≥50mL/min: Start warfarin 3 days before discontinuing dabigatran
  - CrCl 30–50mL/min: Start warfarin 2 days before discontinuing dabigatran
  - CrCl 15–30mL/min: Start warfarin 1 day before discontinuing dabigatran
  - CrCl <15mL/min: No recommendations can be made

  - Since dabigatran can increase INR, the INR will better reflect warfarin’s effect only after dabigatran has been stopped for at least 2 days.

**Switching from DABIGATRAN to PARENTERAL ANTICOAGULANT**

- Currently receiving dabigatran:
  - Wait 12hrs (CrCl ≥30mL/min) or 24hrs (CrCl <30mL/min) after the last dose of dabigatran before initiating treatment with a parenteral anticoagulant

**Conversion of APIxabAn**

**Switching from APIxabAN to WARFARIN**

- Apixaban affects INR levels, so the INR measurement during co-administration with warfarin may not be useful for determining the appropriate dose of warfarin
  - Discontinue apixaban and start both a parenteral anticoagulant and warfarin at the time the next dose of apixaban would have been taken, then discontinue the parenteral anticoagulant when INR reaches an acceptable range

**Switching between APIxabAN and ANTICOAGULANTS other than WARFARIN**

- Discontinue one being taken and begin the other at the next scheduled dose

**Conversion of RIVAROXABAN**

**Switching from RIVAROXABAN to WARFARIN**

- Rivaroxaban affects INR levels, so INR measurements during co-administration with warfarin may not be useful for determining the appropriate dose of warfarin
  - Discontinue rivaroxaban and start both a parenteral anticoagulant and warfarin at the time the next dose of rivaroxaban would have been taken

**Switching from RIVAROXABAN to ANTICOAGULANTS other than WARFARIN**

- Currently taking rivaroxaban and transitioning to an anticoagulant with rapid onset:
  - Discontinue rivaroxaban and give 1st dose of the other anticoagulant (oral or parenteral) at the time the next dose of rivaroxaban would have been taken

**Switching from ANTICOAGULANTS other than WARFARIN to RIVAROXABAN**

- Currently receiving an anticoagulant other than warfarin:
  - Start rivaroxaban 0–2hrs prior to the next scheduled evening dose of the drug (eg, low molecular weight heparin or non-warfarin oral anticoagulant and omit administration of the other anticoagulant)
  - Start rivaroxaban at the same time a continuous infusion of unfractionated heparin is discontinued

**Conversion of HEPARIN**

**Switching from HEPARIN to WARFARIN**

- Dose warfarin with the usual initial amount (eg, 2–5mg PO or IV daily) and determine PT/INR at the usual intervals
- Overlap warfarin with full dose heparin therapy for 4–5 days until warfarin has produced the desired therapeutic response as determined by PT/INR. Heparin may be discontinued at that time without tapering.
- The interference with heparin anticoagulation is of minimal clinical significance during initial therapy with warfarin
- Patients receiving both heparin and warfarin should have blood for PT/INR determination drawn at least:
  - 5hrs after the last IV bolus dose of heparin, or
  - 4hrs after cessation of a continuous IV infusion of heparin, or
  - 24hrs after the last subcutaneous heparin injection

**Switching from HEPARIN/PARENTERAL ANTICOAGULANT to DABIGATRAN**

- Currently receiving a parenteral anticoagulant:
  - Start dabigatran 0–2hrs before the next scheduled dose of the parenteral drug would have been given, or
  - Start dabigatran at the time of discontinuation of a continuously administered parenteral drug (eg, IV unfractionated heparin)

**Conversion of WARFARIN**

**Switching from WARFARIN to DABIGATRAN**

- Discontinue warfarin and start dabigatran when **INR** is <2.0

**Switching from WARFARIN to APIxabAN**

- Discontinue warfarin and start apixaban when **INR** is <2.0

**Switching from WARFARIN to RIVAROXABAN**

- Discontinue warfarin and start rivaroxaban as soon as **INR** is <3.0 to avoid periods of inadequate anticoagulation

**NOTES**

Please see drug monograph at www.eMPR.com and/or contact company for full drug labeling.

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