Conversion of DABIGATRAN ETIXILATE

Switching from DABIGATRAN to WARFARIN

- Adjust starting time of warfarin based on creatinine clearance (CrCl) as follows:
  - CrCl >50mL/min: Start warfarin **3 days** before discontinuing dabigatran
  - CrCl 31–50mL/min: Start warfarin **2 days** before discontinuing dabigatran
  - CrCl 15–30mL/min: Start warfarin **1 day** before discontinuing dabigatran
  - CrCl <15mL/min: Not recommended

- Dabigatran can contribute to an elevated INR, so the INR will better reflect warfarin's effect after dabigatran has been stopped for at least 2 days

Switching from DABIGATRAN to PARENTERAL ANTICOAGULANT

- Adjust starting time of parenteral anticoagulant based on creatinine clearance (CrCl) and timing of last dabigatran dose as follows:
  - CrCl ≥30mL/min: Wait **12 hours** after last dose of dabigatran before initiating treatment with parenteral anticoagulant
  - CrCl <30mL/min: Wait **24 hours** after last dose of dabigatran before initiating treatment with parenteral anticoagulant

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:
  - 5 hours after the last IV bolus dose of heparin, or
  - 4 hours after cessation of a continuous IV infusion of heparin, or
  - 24 hours after the last subcutaneous heparin injection

Switching from HEPARIN/PARENTERAL ANTICOAGULANT to DABIGATRAN

- Adjust starting time of dabigatran based on timing of parenteral anticoagulant dose as follows:
  - Start dabigatran 0 to 2 hours before the time that the next dose of the parenteral anticoagulant (eg, low molecular weight heparin) was to have been administered, 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 wait until INR < 2.0. Then start dabigatran based on creatinine clearance (CrCl) as follows:
  - CrCl >30mL/min: Start dabigatran 150mg twice daily
  - CrCl 15–30mL/min: Start dabigatran 75mg twice daily
  - CrCl <15mL/min or on dialysis: Not recommended

NOTES

For more information, see individual product entries and/or contact company for full labeling.
See Pradaxa entry for more information on dabigatran.
See Coumadin entry for more information on warfarin.
See Heparin sodium entry for more information on heparin.

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