Direct Acting Oral Anticoagulants **– Treatment of Venous Thromboembolism (initiation phase)**

Drug	Dose for treatment of venous thromboembolism (VTE)	Comments
Rivaroxaban	15mg twice daily for the first 21 days	Avoid in creatinine clearance <15ml/min
	20mg once daily from day 22	
Moderate (CrCl 30-49ml/min) or severe (CrCl 15-29ml/min) renal impairment	From day 22 consider trough rivaroxaban anti-xa levels in moderate/severe renal impairment. If levels are high, consider reducing dose to 15mg once daily if patients' assessed risk for bleeding outweighs the risk for recurrent DVT and PE. Contact haematology for advice.	Use with caution in creatinine clearance 15-29ml/min, limited clinical data suggests that rivaroxaban plasma concentrations are significantly increased Note that the 15mg dose has not been studied in the clinical setting and is based on pharmacokinetic modelling.
Apixaban	10mg twice daily for the first 7 days	Avoid in creatinine clearance <15ml/min Use with caution in creatinine clearance 15-29ml/min
	5mg twice daily from day 8	
Edoxaban	Parenteral anticoagulant at treatment dose for first 5 days. Do not give parenteral anticoagulant simultaneously with edoxaban	A trend towards decreasing efficacy with increasing creatinine clearance was observed for edoxaban compared to well-managed warfarin. Edoxaban should only be used in patients with **NVAF** and **high creatinine clearance (>95 ml/min)** after a careful evaluation of the individual thromboembolic and bleeding risk. There is no published data on VTE patients with high creatinine clearance but prescribers may take the data on NVAF into account when considering prescribing edoxaban in VTE.

Standard dose	60 mg once daily from day 6	Avoid in creatinine clearance <15ml/min
In patients with one or more of the following clinical factors: CrCl 15 - 50 mL/min, *body weight ≤ 60 kg or concomitant use of the following P-glycoprotein (P-gp) inhibitors: ciclosporin, dronedarone, erythromycin, or ketoconazole	30 mg once daily from day 6	
Dabigatran	Parenteral anticoagulation at treatment dose for first 5 days. Do not give parenteral anticoagulant simultaneously with dabigatran	Avoid in creatinine clearance <30ml/min
Standard dose Patients aged 18-74 years	150mg twice daily from day 6	
Patients aged ≥80 years Patients who receive concomitant verapamil	110mg twice daily from day 6	
Patients aged between 75-80 years CrCl 30-50 mL/min Patients with gastritis, esophagitis or gastroesophageal reflux Other patients at increased risk of bleeding	150mg twice daily or 110mg twice daily from day 6	dose should be selected based on an individual assessment of the thromboembolic risk and the risk of bleeding

*Edoxaban dosing weight as per current SPC, differs from BNF

Note: **CrCl (creatinine clearance) and not eGFR should be used to calculate renal function and dosing for DOACs**. For CrCl calculation equation click here . For further information see MHRA drug safety update The duration of VTE treatment should be decided by the in-patient team where possible and documented on the discharge summary.
For more detailed prescribing information click on drug: rivaroxaban smpc apixaban smpc edoxaban smpc dabigatran smpc

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