Switching Anticoagulants Guidelines for switching from other forms of anticoagulation to DOACs

From	To Edoxaban	To Rivaroxaban	To Apixaban	To Dabigatran
Warfarin	Stop warfarin Start edoxaban when INR ≤2.5	Stop warfarin Start rivaroxaban when INR ≤3.0 (AF) Or ≤2.5 (VTE)	Stop warfarin Start apixaban when INR <2.0	Stop warfarin Start dabigatran when INR<2.0
Heparin Infusion	Give first dose of DOAC at time heparin infusion discontinued			
Low molecular weight heparin	Give first dose of DOAC 0-2 hours prior to time next dose of low molecular weight heparin due Do not give any further doses of low molecular weight heparin			

Guidelines for switching from DOACs to other forms of anticoagulation

From	To	
Apixaban, Rivaroxaban, Edoxaban, Dabigatran	Heparin infusion or low molecular weight heparin	Start heparin infusion /give first dose of low molecular weight heparin at time next dose of DOAC is due Do not give any further doses of DOAC
Rivaroxaban	Warfarin	Give warfarin and rivaroxaban concurrently until INR ≥ 2.0 *(see notes below) For the first 2 days of the conversion period standard initial dosing of warfarin should be used followed by dosing guided by INR testing. *While patients are on both rivaroxaban and warfarin the INR should only be tested **24 hours after the dose of rivaroxaban or just prior to the next dose as rivaroxaban can falsely elevate the INR**
Apixaban	Warfarin	Continue apixaban for at least 2 days after starting warfarin and until INR >2.0 Take INR before next scheduled dose of apixaban

Dabigatran	Warfarin	CrCL ≥ 50 mL/min, warfarin should be started 3 days before stopping dabigatran CrCL ≥ 30-< 50 mL/min, warfarin should be started 2 days before stopping dabigatran (Because dabigatran can affect the INR for 2 days after stopping, INR values should be monitored with caution until after this time)
Edoxaban	Warfarin	For patients on 60mg dose, give 30mg dose edoxaban together with appropriate warfarin dose (estimated maintenance dose, do not load) For patients on 30mg dose, give 15mg edoxaban together with appropriate warfarin dose (estimated maintenance dose, do not load) Stop edoxaban when INR ≥2 (INR should be taken just prior to edoxaban dose to minimise its influence on the reading) See edoxaban smpc for further information

For further information on INR testing after switching from a DOAC to warfarin, see individual drug monographs at www.medicines.org

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