GP Practice Guidance – Dec 2019

This document is for guidance, and does not supersede the requirements of the LES

1. **Continuation of DOAC Therapy – treatment initiated in hospital**
2. **Initiation of DOAC’s in GP Practices**
3. **Renal Function Monitoring**
4. **Conversion from Warfarin to DOAC / DOAC to Warfarin**
5. **Useful Resources ( see GP Portal / stopastroke website )**
   1. DOAC counselling checklist
   2. UKMI – Common Q and A’s
   3. Option grid – patient decision aid
   4. European Heart Rhythm Association Practical Guide on the use of DOACs in non-valvular AF
   5. Antiplatelets and antithrombotics
   6. Assessment and management of bleeding risks in patients requiring oral anticoagulation for atrial fibrillation
   7. HAS BLED score table
   8. MHRA training resource – free to register
   9. Scottish “SIGN” Guidance for Dental Procedures
   10. Prescriber Decision Support, Greater Manchester Medicines Management Group Nov 2015

**Continuation of DOAC Therapy**

1. Practice to receive DOAC initiation form and eDAL containing information from hospital
2. Code indication for treatment on patient record
3. Document treatment period if applicable
4. Document HAS BLED and CHADSVASC scores on to patient record (for NVAF patients only)
5. Document latest Creatinine clearance ml/min (from DOAC initiation form).
6. Check if patient is on antiplatelet – remove from medication if indicated on DOAC form – for short term DOAC treatment, make a note to restart antiplatelet once DOAC stops if appropriate.
7. Check for any other medication causing interactions eg NSAID’s
8. Add to acute medication for patient DOAC prophylaxis read code 8B611
9. Book follow up appointment ( telephone or face to face ) with GP / practice pharmacist in 3-6 weeks to complete the following;
   1. Check patient understanding using counselling checklist
   2. Scan counselling checklist on to patient notes

(practice may set up counselling checklist as template )

* 1. Document BP if no recent result, body weight and height
  2. Anticoagulation monitoring – primary care 66QD

1. If follow up satisfactory, add medication to repeat list for future ordering. Please indicate date for treatment to stop if applicable
2. Document frequency of monitoring and inform patient – see guidance below on monitoring
   1. All patients should have a face to face **annual** review by an appropriate healthcare professional including bloods and using counselling checklist or template Read code 8BT3 – Anticoagulation Medication Review

Ongoing Monitoring

1. All patients to have renal function, FBC and LFT monitoring at least annually
2. Monitor renal function every 6 months;

* If creatinine clearance is 30-60mL/min,
* patient is 75years or older or fragile.
* On dabigatran

1. Monitor renal function every 3 months;

* If creatinine clearance is 15-30mL/min

1. Review if patients clinical condition changes.

**Renal Functio**n

Calculate CrCl. Use actual body weight

<https://www.mdcalc.com/creatinine-clearance-cockcroft-gault-equation>

**Initiation of DOAC’s for Stroke Prevention in non-valvular AF in GP Practices**

* 1. Document indication for treatment

Use tools to establish HAS BLED and CHADSVASC scores (for NVAF). E.g <http://www.sparctool.com>

Select appropriate treatment options using risk/benefit information

* 1. Document HASBLED and CHADSVASC scores
  2. Discuss treatment options with patients using risk / benefit information from tool (or pt option grid – see useful resources )
  3. If patient declines a DOAC - read code 8IH1
  4. Check if pt is on antiplatelet – review and remove from medication if appropriate (see useful resources)
  5. Check if pt on other medication causing interactions eg NSAID’s and discontinue where possible
  6. If DOAC to be prescribed arrange blood tests (if not done in last 6 weeks)
     1. FBC
     2. Kidney function –Cr Cl
     3. LFT’s
     4. Clotting screen - request form must be labelled “baseline prior to anticoagulation treatment” or similar, otherwise lab may refuse to process. Do not request if patient switching from warfarin
  7. Add to acute medication for patient DOAC prophylaxis read code 8B611
  8. Document blood pressure
  9. Document body weight ( needed for Apixaban and CrCl calculation). If patient below 40kg or above 120kg please contact haematology for advice before starting treatment. (below 50kg for Dabigatran )
  10. Counsel patient fully using counselling checklist

-Ensure patient aware of importance of compliance

* 1. Ensure patient aware of antidote information
  2. Practices may want to scan the counselling checklist on to patient notes or use practice template
  3. Face to Face annual review is a minimum for all patients - to be guided by patient age, renal function and clinical considerations - read code 8BT3. See information for frequency of monitoring.

Before Prescribing;

* Check blood results
  + If clotting screen abnormal contact the duty Haematologist via switchboard at PCH or RGH for advice before starting treatment
* DO NOT use a DOAC if Cr Cl <15mL/min (or < 30mL/min for Rivaroxaban and dabigatran. Caution with Edoxaban) )
* First prescription DOAC prophylaxis read code 8B611
  + 1. If bloods all within range and suitable for treatment choice, patient can collect prescription from practice or have prescription sent to a community pharmacy
    2. If bloods NOT in range for treatment choice contact patient for appointment .
* Ensure correct choice and dose of DOAC used ( see useful resources on portal)
* Read code 8B3A3 ( new medication commenced so that patients initiated in the practice can be identified )
* Ensure patient is aware of the alert/information card (see useful resources). Practices can ask for supplies from the pharma companies or they are available in each pack of medication
* Book 3-6 week follow up face to face or telephone appointment with GP / practice pharmacist to check on tolerability and re-counsel
  + 1. Counsel patient fully using counselling checklist or template ( see counselling checklist)
    2. Scan counselling checklist on to patient notes
    3. Read code 66QD

If follow up satisfactory, add medication to repeat list with monitoring frequency or treatment time if applicable.

**Renal Functio**n

Calculate CrCl as below.

<https://www.mdcalc.com/creatinine-clearance-cockcroft-gault-equation>

**Ongoing Monitoring**

1. All patients to have renal function, LFT and FBC at least annually
2. Monitor renal function every 6 months;

* If creatinine clearance is 30-60mL/min,
* patient is 75years or older or fragile.
* On dabigatran

1. Monitor renal function every 3 months;

* If creatinine clearance is 15-30mL/min

1. Review at any point if patients clinical condition changes.

**SPC Information – Renal Impairment**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Use of DOAC’s for prevention of stroke in Nonvalvular Atrial Fibrillation patients, with renal impairment** | | | | |
| **Calculated Cr Cl (ml/min)** | **Rivaroxaban** | **Apixaban** | **Dabigatran** | **Edoxaban** |
| >80 | 20mg OD | 5mg BD | 150mg BD | 60mg OD |
| 51-80 | 20mg OD | 5mg BD | 150mg BD | 60mg OD |
| 30-50 | **15mg OD with food** | 5mg BD | Patients at high risk of bleeding or on interacting meds- consider maximum of **110mg BD** | **30mg OD** |
| <30 | Avoid | **2.5mg BD**  **Use with Caution1** | Avoid | **Use with caution2** |
| <15 | Avoid | Avoid | Avoid | Avoid |

**1SPC for Apixaban** - For the prevention of stroke and systemic embolism in patients with NVAF, patients with severe renal impairment (creatinine clearance 15-29 mL/min), and patients with serum creatinine ≥ 1.5 mg/dL (133 micromole/L) associated with age ≥ 80 years or body weight ≤ 60 kg should receive the lower dose of apixaban 2.5 mg twice daily- **However limited clinical experience**

**2SPC for Rivaroxaban-** In patients with moderate (creatinine clearance 30 - 49 ml/min) or severe (creatinine clearance 15 - 29 ml/min) renal impairment, for the prevention of stroke and systemic embolism in patients with non-valvular atrial fibrillation, the recommended dose is 15 mg once daily. **However limited clinical experience**

**For further information please consult the product SPC**

Conversion from Warfarin to DOAC

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| --- |
| **To Rivaroxaban**  Prevention of stroke and systemic embolism, discontinue VKA treatment and Rivaroxaban initiated when the INR is ≤ 3.0.  DVT, PE and prevention of recurrence, discontinue VKA treatment and Rivaroxaban initiated once the INR is ≤ 2.5. |
| **To Apixaban**  Warfarin or other VKA therapy should be discontinued and Apixaban started when the international normalised ratio (INR) is < 2. |
| **To Edoxaban**  Warfarin or other VKA should be discontinued Edoxaban when the INR is ≤ 2.5. |
| **Dabigatran**  Warfarin or other VKA should be discontinued and Dabigatran etexilate started when the INR is < 2.0 |

Conversion from DOAC to Warfarin ( if DOAC not tolerated or unsuitable) - Seek advice from hospital

**Please report any side effects for DOAC’s on the Yellow Card system**

**If DOAC not tolerated please code 8I7V**

**Summary of Codes**

8B611 - DOAC prophylaxis code. To be added when DOAC treatment added to medication either following initiation in primary care or continuation from secondary care

8BT3 - Anticoagulation Medication Review. For DOAC annual review of any patient on treatment.

66QD – Anticoagulation monitoring – primary care. For the 4-6 week review and any other reviews clinically indicated. Max 4 reviews in total per year for claims.

8B3A3 – New medication commenced. For patients initiated on a DOAC in primary care only.

8IH1 – DOAC declined. If patient reviewed for treatment to be initiated in primary care but declines following provision of information about treatment

**Other codes**

DOAC alert card 66c5

DOAC contra-indicated 8I2u

**Useful Resources**; ( see GP portal )