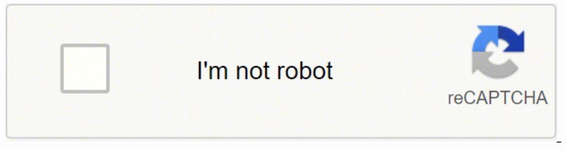

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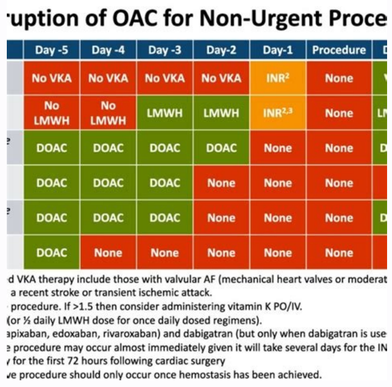
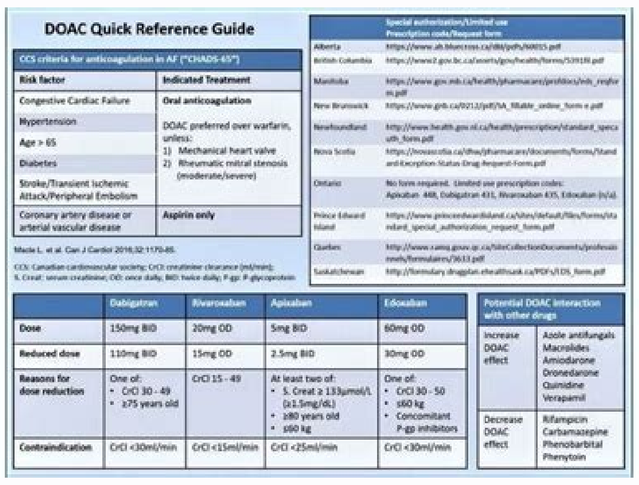
Anticoagulation guidelines canada



'uption of OAC for Non-Urgent Proce

	Day -5	Day -4	Day -3	Day-2	Day-1	Procedure	D
	No VKA	No VKA	No VKA	No VKA	INR[2]	None	
	No LMWH	No LMWH	LMWH	LMWH	INR[2,3]	None	LM
	DOAC	DOAC	DOAC	DOAC	None	None	D
	DOAC	DOAC	DOAC	None	None	None	
	DOAC	DOAC	DOAC	None	None	None	D
	DOAC	None	None	None	None	None	

d VKA therapy include those with valvular AF (mechanical heart valves or moderat
a recent stroke or transient ischemic attack.
procedure. If >1.5 then consider administering vitamin K PO/IV.
(or ½ daily LMWH dose for once daily dosed regimens).
apixaban, edoxaban, rivaroxaban) and dabigatran (but only when dabigatran is use
e procedure may occur almost immediately given it will take several days for the IN
/ for the first 72 hours following cardiac surgery
ve procedure should only occur once hemostasis has been achieved.



DOAC Quick Reference Guide

CCS criteria for anticoagulation in AF ("CHADS-65")

Risk factor	Indicated Treatment
Congestive Cardiac Failure	Oral anticoagulation
Hypertension	DOAC preferred over warfarin, unless: 1) Mechanical heart valve 2) Rheumatic mitral stenosis (moderate/severe)
Age > 65	
Diabetes	
Stroke/Transient Ischemic Attack/Peripheral Embolism	
Coronary artery disease or arterial vascular disease	Aspirin only

Macle L. et al. Can J Cardiol 2016;32:1170-86.

CCS: Canadian cardiovascular society; CrCl: creatinine clearance (ml/min); S. Creat: serum creatinine; OD: once daily; BID: twice daily; P-gp: P-glycoprotein

	Special authorization/Limited use Prescription code/Request form
Alberta	https://www.ab.bluecross.ca/dbb/pdfs/NANES.pdf
British Columbia	https://www2.gov.bc.ca/assets/gov/health/forms/539186.pdf
Manitoba	https://www.gov.mb.ca/health/pharmacare/profdocs/mds_reqform.pdf
New Brunswick	https://www.gnb.ca/0212/pdf/NA_fillable_online_form-e.pdf
Newfoundland	http://www.health.gov.nl.ca/health/prescription/standard_specauth_form.pdf
Nova Scotia	https://novascotia.ca/dhw/pharmacare/documents/forms/Standard-Exception-Status-Drug-Request-Form.pdf
Ontario	No form required. Limited use prescription codes: Apixaban 448, Dabigatran 435, Rivaroxaban 435, Edoxaban (n/a).
Prince Edward Island	https://www.princeedwardisland.ca/sites/default/files/forms/standard_special_authorization_request_form.pdf
Quebec	http://www.ramq.gouv.qc.ca/SiteCollectionDocuments/professionnels/formulaires/36133.pdf
Saskatchewan	http://formulary.drugplan.ehealthsask.ca/PDFs/LDS_form.pdf

	Dabigatran	Rivaroxaban	Apixaban	Edoxaban
Dose	150mg BID	20mg OD	5mg BID	60mg OD
Reduced dose	110mg BID	15mg OD	2.5mg BID	30mg OD
Reasons for dose reduction	One of: • CrCl 30 - 49 • ≥75 years old	CrCl 15 - 49	At least two of: • S. Creat ≥ 133µmol/L (≥1.5mg/dL) • ≥80 years old • ≤60 kg	One of: • CrCl 30 - 50 • ≤60 kg • Concomitant P-gp inhibitors
Contraindication	CrCl <30ml/min	CrCl <15ml/min	CrCl <25ml/min	CrCl <30ml/min

Potential DOAC interaction with other drugs	
Increase DOAC effect	Azole antifungals Macrolides Amiodarone Dronedarone Quinidine Verapamil
Decrease DOAC effect	Rifampicin Carbamazepine Phenobarbital Phenytoin

Anticoagulation Guidelines for Regional Anesthesia and Analgesia

Wake Forest University RAAPM recommendations to avoid increasing the risk of neuraxial hematoma following neuraxial analgesic/anesthetic procedures.*

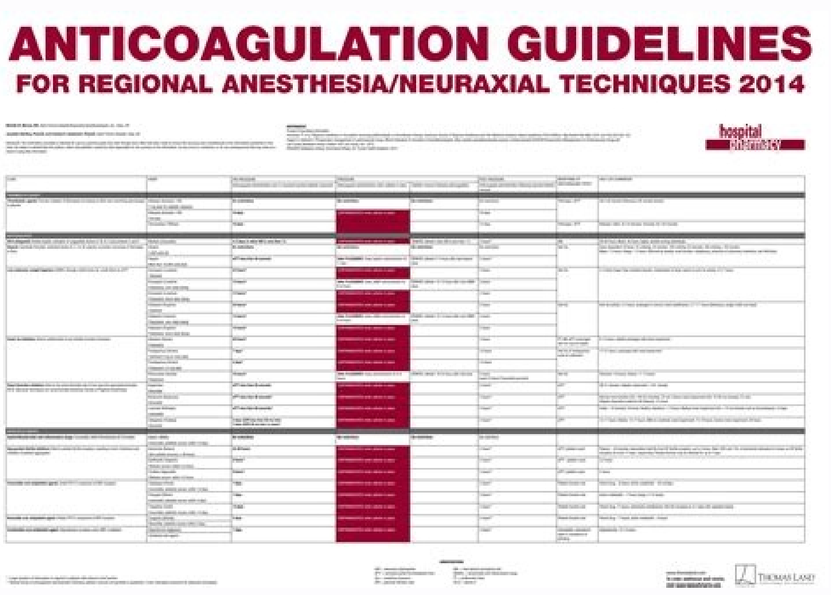
Anticoagulant (half-life)	Anticoagulant Type	MINIMUM delay between last dose of anticoagulant and performance of neuraxial technique	MINIMUM delay between neuraxial technique or catheter removal and next anticoagulant dose	Other pre-cautions
Heparin (Unfractionated)* Intravenous (1.5h)**	Pro–antithrombin III (anti II,X)	2-4h, and aPTT WNL**	≥1 hour[1]	†
Heparin (Unfractionated)* (1.5h) SQ BID ≤10,000u/day**	Pro–antithrombin III (anti II,X)	No restriction[1], caution during peak 1-4h post dose.**	No restriction[1]	†
Heparin (Unfractionated)* (1.5h) SQ TID ≥10,000u/day**	Pro–antithrombin III (anti II,X)	Insufficient data and caution advised.[1] ≥6 hours**	≥1 hour[1] (Unless first dose then no restriction.)**	†
Enoxaparin (Lovenox) (3-6h) prophylaxis 40mg QD or 30mg BID	LMWH Anti-Xa	12 hours[1]	Initiate ≥4 hours post removal.[1] (BID use not recommended with indwelling catheter)[1,3]	†
Enoxaparin (Lovenox) (3-6h) therapeutic 1mg/kg BID or 1.5mg/kg QD	LMWH Anti-Xa	24 hours[1]	Not recommended with catheter[1] Initiate ≥4h post removal.**[3]	†
Fondaparinux (Arixtra) (17-21h)	Pentasaccharide Anti-Xa	4.5 days and/or heparin assay.**	Contraindicated with catheter[1] Initiate ≥2h post removal. **	†
Rivaroxaban (Xarelto) (5-13h)	Anti-Xa	48-72h** For catheter removal 22-26h[2]	6h, or 24h if traumatic insertion (package insert) [2]	†,††
Warfarin (Coumadin) (60 h)	Vit K-dependent Factor Inhibition	4-5 days & INR WNL (≤ 1.2)[1] For removal INR ≤ 1.5.[1]	Guided by INR[1]	†
Aspirin/NSAIDS (>72h)	Anti-Platelet	No restrictions[1]	No Restrictions[1]	
Clopidogrel (Plavix) (6-8 h)	Irreversible platelet aggregation inhibitor	7 days[1]	Not recommended with catheter[1] Initiate ≥2h post removal.**	
Ticlopidine (Ticlid) (4-5 days with repeated doses)	Irreversible platelet aggregation inhibitor	14 days [1]	Not recommended with catheter[1] Initiate ≥2h post removal.**	
Prasugrel (Effient) (7 h)	Irreversible platelet aggregation inhibitor	7-10 days[2]	Not recommended with catheter[2] Initiate ≥2h post removal.**	
Ticagrelor (Brilinta) (7-12h)	ADP *reversible* receptor blocker	5 days[2]	Not recommended with catheter[2] Initiate ≥2h post removal.**	††
Abciximab (Reopro) (30 minutes)	Glycoprotein IIb/IIIa inhibitor	48 hours[1]	Not recommended with catheter[1] Initiate ≥2h post removal.**	
Eptifibatide (Integrilin) (2.5h)	Glycoprotein IIb/IIIa inhibitor	8 hours[1]	Not recommended with catheter[1] Initiate ≥2h post removal.**	
Tirofiban (Aggrastat) (2h)	Glycoprotein IIb/IIIa inhibitor	8 hours[1]	Not recommended with catheter[1] Initiate ≥2h post removal.**	
Bivalrudin (Angiomax) Desirudin (Iprivask) Argatroban (Acova)	Thrombin (II) Inhibitor (IV)	Insufficient data.[1] Neuraxial techniques not recommended.**	Insufficient data.[1]	
Dabigatran (Pradaxa) (17 h) (prolonged with CRI)	Thrombin (II) Inhibitor (oral)	5 days**	Not recommended with catheter[1] Initiate ≥6h post removal.[2]	†
Apixaban (Eliquis) (12-15h)	Oral Factor Xa Inhibitor	4 days**	≥6 h[2]	††

Note: Recommendations are based on single drug use, combinations increase risk. Caution if traumatic neuraxial technique.

* Recommendation compliance does not eliminate the risk for neuraxial hematoma.
** Our current practice, no current published guidelines.
***Patients receiving unfractionated heparin should have platelet count checked after 4 days to monitor for possible heparin induced thrombocytopenia (HIT).
† Caution with CRI, low weight, elderly.
†† T ½ doubled with strong CYP3A4 inhibitors (anti-fungals, antiretrovirals).

References: [1] ASRAPM Evidence-Based Guidelines 2010: "Regional Anesthesia in the Patient Receiving Antithrombotic or Thrombolytic Therapy". [2] Regional anesthesia and Antithrombotic agents: recommendations of the European Society of Anesthesiology. [3] ASRA Safety Announcement: Updated recommendations to decrease risk of spinal column bleeding and paralysis in patients on low molecular weight heparins, 11/6/13.

Version 4.0, 3/2014 (Henshaw, Jaffe, Weller)



ANTICOAGULATION GUIDELINES

FOR REGIONAL ANESTHESIA/NEURAXIAL TECHNIQUES 2014

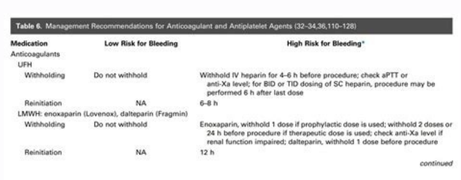


Table 6. Management Recommendations for Anticoagulant and Antiplatelet Agents (32–34,36,110–128)

Medication	Low Risk for Bleeding	High Risk for Bleeding*
Anticoagulants		
UFH		
Withholding	Do not withhold	Withhold IV heparin for 4–6 h before procedure; check aPTT or anti-Xa level; for BID or TID dosing of SC heparin, procedure may be performed 6 h after last dose
Reinitiation	NA	6–8 h
LMWH: enoxaparin (Lovenox), dalteparin (Fragmin)		
Withholding	Do not withhold	Enoxaparin, withhold 1 dose if prophylactic dose is used; withhold 2 doses or 24 h before procedure if therapeutic dose is used; check anti-Xa level if renal function impaired; dalteparin, withhold 1 dose before procedure
Reinitiation	NA	12 h

continued

Stroke anticoagulation guidelines canada. Anticoagulation guidelines. Anticoagulation guidelines 2020. Perioperative anticoagulation guidelines thrombosis canada. Anticoagulation guidelines 2021. Afib anticoagulation guidelines canada.

Norouze S, Benzon HT, Provenzano D, Buvanendran A, by Andres J, Deer T, et al. Posted on April 30, 2019. The Ways of Treatment of DOAC Principle Operating found that 90% of patients or more reached a number = 50 ml/min, Apixaban and Rivaroxaban, anticoagulation was performed for 1 day before the low risk procedures (without DOAC on day -1) and 2 days before high risk procedures (Do not doac on day -2 or day -1). The university offers hundreds of graduation and dozens of programs of poses graded, giving students the flexibility of pursuing their interests. It is far away from the two back of Canadan, the University of the University of Calgary offers education in the groups of graduation, poses -gradation and pits. Elina Liu MD (Biography, without disclosures), Erin Morley MD (Biography, without disclosures) and Anna Rahmani MD (Biography and Disclosure) Disclosure for Dr. Anna Rahmani: received funding for subsidiaries/research: University of Ottawa Blood Disease Center (not supported by pharmacoms). There were no changes in these intervals for patients with reduced dose anticoagulation. 2018; 43 (3): 263-309. For patients in Dabigatran with CRCL

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