DOAC: VTE Treatment Courses

Rivaroxaban: 15 mg twice daily x 21 days → 20 mg daily

Apixaban: 10 mg twice daily x 7 days → 5 mg twice daily → *2.5 mg twice daily**

* Optional at 6 months

Parenteral Anticoagulation 5-10 days FIRST → **Dabigatran:** 150 mg twice daily

Parenteral Anticoagulation 5-10 days FIRST → **Edoxaban:** 60 mg daily

DOAC: VTE Treatment Dosing

VTE Treatment	Dabigatran	Apixaban	Rivaroxaban	Edoxaban
Initial Treatment Dose	150 mg BID AFTER 5-10 days parenteral anticoagulation (i.e. heparin or LMWH)	10 mg BID for 7 days → 5 mg BID	15 mg BID for 21 days → 20 mg daily with food	60 mg daily AFTER 5-10 days parenteral anticoagulation (i.e. heparin or LMWH)
Risk of Recurrence Reduction	150 mg BID (if CrCl >30 ml/min) *After previous treatment	2.5 mg BID *After ≥6 months	10 mg daily (with/without food) *After ≥6 months	Not in labeling
Renal Dosing (ml/min)	**CrCl <30:** AVOID	**No dose adjustment** *(CrCl <25 not studied)*	**CrCl <30:** AVOID	**CrCl 15 – 50:** 30mg **CrCl <15:** AVOID

DOAC: AFib Dosing

Dosing	Dabigatran	Apixaban	Rivaroxaban	Edoxaban
Normal AFib Dosing	150 mg BID	5 mg BID	20 mg daily with evening meal	60 mg daily
Renal AFib Dosing (CrCl ml/min)	**CrCl 15 – 30:** 75 mg BID **CrCl <15 or Dialysis:** AVOID	2.5 mg BID ONLY if ≥2 of the following: **A**: Age ≥80 years **B:** Body weight ≤60 kg **C:** Serum Creatinine ≥1.5 mg/dL	**CrCl 15 – 50:** 15 mg with pm meal **CrCl <15:** AVOID	**CrCl 15 – 50:** 30 mg daily **CrCl <15 or >95:** AVOID
Renal Elimination	80%	27%	66%	50%

Warfarin Conversion to DOACs

DOAC	Conversion FROM Warfarin TO a DOAC
Rivaroxaban	STOP warfarin and START rivaroxaban when INR **<3.0**
Edoxaban	STOP warfarin and START edoxaban when INR **<2.5**
Apixaban	STOP warfarin and START apixaban when INR **<2.0**
Dabigatran	STOP warfarin and START dabigatran when INR **<2.0**