NHS
North East London

Guidance for North East London Community Anticoagulation Providers on the safe switching of warfarin to direct oral anticoagulants (DOACs) for patients with non-valvular AF

Document control

Title	Guidance for the safe switching of warfarin to direct oral anticoagulants (DOACs) for patients with non-valvular AF in North East London
Version	1.0
Produced by	North East London Pharmacy and Medicines Optimisation Team
Approved by	North East London Formulary and Pathways Group (FPG)
Date approved	09/12/2025
Ratified by	North East London System Prescribing and Medicines Optimisation (SyPMO) Board
Date ratified	Dec 2025
Review date	Dec 2028

This document serves to provide guidance to **NEL Community Anticoagulation Service** providers on the process and clinical considerations that should be undertaken to ensure the safe and appropriate switch of suitable patients with **non-valvular AF (NVAF)** established on warfarin to a DOAC.

1. Aim of Guidance

NVAF refers to atrial fibrillation (AF) in the absence of a mechanical prosthetic heart valve or moderate to severe mitral stenosis/mitral valve disease.

Patients should only be switched from warfarin to a DOAC in primary care by NEL Community Anticoagulation Service providers. Switching from warfarin to a DOAC must be done with careful consideration as not all patients taking warfarin are suitable for a switch to DOAC, and in some cases, specialist advice may be required.

2. Background Information

NICE Guidance on the diagnosis and management of atrial fibrillation (NG196) recommends DOACs as the first line treatment for stroke prevention in NVAF due to their relative effectiveness, increased safety and convenience compared to warfarin.

DOACs show consistently lower risk of major bleeding including intracranial haemorrhage when compared to vitamin K antagonists such as warfarin.

Whilst DOACs require blood tests to assess renal function throughout treatment– the monitoring is predictable and significantly less frequent than INR testing with warfarin, with most patients requiring an annual blood test.

3. Which patients are suitable for a switch from warfarin to DOAC?

Switching from warfarin to a DOAC by NEL Community Anticoagulation Providers is only recommended for patients with Non-Valvular Atrial Fibrillation who are currently prescribed warfarin for the sole indication of stroke prevention.

Patients with poor control of INR, time in therapeutic range (TTR) < 65%, should be prioritised, the importance of adherence to DOAC treatment should be explained.

Patients should only be switched from warfarin to a DOAC following a shared decision with the patient or patient representative and reasons for suggesting switch and pros and cons explained.

4. Exclusion Criteria

Community Anticoagulation Service Providers **should not** switch the following patient groups with NVAF from warfarin to a DOAC:

- Patients with known allergy or hypersensitivity to DOACs
- Patients with NVAF who have an additional indication for anticoagulation including but not limited to: diagnosed venous thromboembolism (DVT/PE), mechanical heart valve, antiphospholipid antibody syndrome (APLS)

- Patients who are pregnant, breastfeeding or planning a pregnancy
- Patients requiring a higher INR than the standard INR range of 2.0 – 3.0
- Patients with significant renal (CrCl < 15ml/min) or liver disease
- Patients with active malignancy/chemotherapy (unless advised by a specialist)
- Patients with a history of clinically significant bleeding (refer to haematology)
- Patients prescribed interacting drugs – check SPCs (links below) for full list
    - Some HIV antiretrovirals and hepatitis antivirals - check with HIV drug interactions website at https://www.hiv-druginteractions.org/
    - Some antiepileptics- phenytoin, carbamazepine, phenobarbitone or rifampicin are likely to reduce DOAC levels so should be discussed with a haematology specialist
- Patients with bodyweight ≥140kg. These patients should be referred to haematology for switching from warfarin to a DOAC.
- Patients with body weight ≥120kg and <140kg who also have additional high-risk factors for thrombosis e.g. peripheral vascular disease, previous cardiovascular thrombosis. These patients should be discussed with haematology prior to switching to a DOAC.
- Patients under the age of 18 years old

If a patient is **unsuitable** for switching to a DOAC, the reason should be documented in the patient's electronic medical record.

Patients with NVAF who have TTR < 65% and are not suitable for switch to DOAC, supplemental measures may be required including (re-)educating patients on the risk and benefits of warfarin intake, the importance of strict adherence as well as food and drug-drug interactions etc. These patients may need to be escalated to secondary care anticoagulation service providers.

5. Choice of DOAC for Non-Valvular Atrial Fibrillation

All DOACs (apixaban, rivaroxaban, edoxaban and dabigatran) are licensed for stroke prevention in patients with non-valvular AF. In the absence of direct comparison trials, it is not possible to recommend one DOAC over another, but NHS England has recommended clinicians should use the **best value DOAC**[1]. As of September 2024, generic apixaban and generic rivaroxaban tablets represent best value (Preferred-DOAC-prescribing-position-statement-NEL).

Patients should be switched to **generic apixaban or rivaroxaban tablets** which are first line formulary choice across NEL for stroke prevention in NVAF**.**

Edoxaban and dabigatran should not routinely be initiated unless both apixaban and rivaroxaban are contraindicated.

Refer to the following NEL guidelines at NEL Medicines Optimisation Primary Care Information Portal (NEL Folder) prior to DOAC initiation:

1. **NEL DOAC Initiation and Monitoring Template** for information on:
    - Choice of DOAC
    - Monitoring
    - Counselling Checklist
2. **NEL DOAC initiation Checklist**
3. **NEL DOAC Calculating Renal Function**
4. Summary of Product Characteristics (SmPC) for the chosen DOAC available at https://www.medicines.org.uk/emc

6. Pragmatic Approach to Stopping Warfarin and Starting DOAC in relation to INR

SPCs recommend different INRs at which to initiate DOACs after stopping warfarin:

Apixaban and Dabigatran: Start when INR < 2

Rivaroxaban: Start when INR < 3

Edoxaban: Start when INR < 2.5

This approach would require repeat INR checks daily until the required INR is achieved.

EHRA guidance[2] gives pragmatic guidance on when to start DOACs after stopping warfarin without needing repeat daily INR checks:

If INR ≤ 2	Stop warfarin and start DOAC on the same day
If INR between 2 and 2.5	Stop warfarin and start DOAC on the next day (ideally) or on the same day
If INR between 2.5 and 3.0	Withhold warfarin for 24-48 hours and then initiate DOAC

7. Checklist for switching a patient with NVAF from warfarin to a DOAC

It is the responsibility of the Community Anticoagulation Provider to ensure **that the following steps are** undertaken when switching a patient with NVAF from warfarin to a DOAC prior to discharging the patient and transferring them back to their registered GP for ongoing DOAC monitoring.

	Checklist for switching a patient with NVAF from warfarin to a DOAC	Completed
1.	Identify patients currently prescribed warfarin for the sole indication of NVAF who are suitable for switching to a DOAC as per this guideline Prioritise patients with a TTR < 65% subject to patient adherence to DOAC therapy.	
2.	Discuss the proposed change with the patient/carer. This may be undertaken at the next scheduled INR check.	
3.	Check the GP clinical system for recent U&Es, LFTs and FBC (within last 3 months). If not available, request that bloods are ordered. Take a weight if recent weight is not available on the clinical system.	
4.	Calculate a creatinine clearance use the Cockcroft and Gault formula.	
5.	Choose a DOAC and dose as per **NEL Initiation and Monitoring Template** and prescribe **two months** of the selected DOAC.	

	Advise patient on 1) where to collect supply (nominated community pharmacy) 2) that subsequent prescriptions will be issued by that patient's registered GP	
6.	Remove warfarin from the patient's repeat list on the GP Clinical System detailing "switched to DOAC" as the reason for stopping warfarin.	
7.	Advise the patient when to stop warfarin in relation to starting DOAC. Provide written instructions and involve family members / carers where possible to minimise the risk of patients taking both warfarin and the DOAC concurrently. Particular care should be taken where patients are using medication compliance aids to minimise the risk of incorrect dosing	
8.	Inform the patient's community pharmacy that warfarin is stopped and a DOAC has been initiated.	
9.	Counsel the patient using **NEL DOAC Initiation Checklist** and advise patient to carry a DOAC alert card which can be found inside the dispensed box of DOAC. Reiterate the importance of adherence to DOAC treatment.	
10.	Ensure the following details are recorded in the consultation notes on the GP Clinical System: • Suitability for switch to DOAC • Rationale for choice and dose of DOAC prescribed • Instructions given to patient on when to stop warfarin and start DOAC • Counselling completed with patient Recommended monitoring depending on renal function	
11.	Follow up with a patient consultation within **one month** of initiation to review side-effects/ bleeding issues and patient adherence to therapy. Following this review, communicate to the patient and their registered GP that ongoing DOAC care will be provided by the patient's registered GP. Non adherent patients may need to be escalated to secondary care anticoagulation service providers.	
12.	When the transfer of care to the patient's registered GP has been completed, deactivate the patient on INRstar, detailing "switched to DOAC" as the reason for stopping warfarin.	

7. Resources for Healthcare Professionals

NEL Guidance on initiation of DOACs available on NEL Medicines Optimisation Primary Care Information Portal (NEL Folder)

NEL DOAC Initiation and Monitoring Template
NEL DOAC Checklist
NEL DOAC Calculating Renal Function

DOAC risk minimisation materials (prescribing guide) for Healthcare Professional from proprietary manufacturers

Apixaban	https://www.medicines.org.uk/emc/rmm/113/Document
Rivaroxaban	https://www.medicines.org.uk/emc/rmm/626/Document
Edoxaban	https://www.medicines.org.uk/emc/rmm/226/Document
Dabigatran	https://www.medicines.org.uk/emc/rmm/399/Document

8. Resources for Patients

DOAC Information

NHS Direct Oral Anticoagulant (DOAC) Booklet	https://bsw.icb.nhs.uk/wp-content/uploads/sites/6/2022/10/DOAC-Therapy-book_159E27.pdf
Patient information leaflet: Apixaban	https://www.medicines.org.uk/emc/files/pil.14535.pdf
Patient information leaflet: Rivaroxaban	https://www.medicines.org.uk/emc/files/pil.15760.pdf
Patient information leaflet: Edoxaban	https://www.medicines.org.uk/emc/files/pil.6905.pdf
Patient information leaflet: Dabigatran	https://www.medicines.org.uk/emc/files/pil.15850.pdf

9. References

1. NHSE Commissioning recommendations for national procurement for direct-acting oral anticoagulant(s) (DOACs) https://www.england.nhs.uk/long-read/commissioning-recommendations-for-national-procurement-for-doacs/
2. The 2018 European Heart Rhythm Association Practical Guide on the use of non-vitamin K antagonist oral anticoagulants in patients with atrial fibrillation

https://academic.oup.com/eurheartj/article/39/16/1330/4942493?guestAccessKey=e7e62356-8aa6-472a-aeb1-eb5b58315d49

3. Guidance for the safe switching of warfarin to direct oral anticoagulants (DOACs) for patients with non-valvular AF and venous thromboembolism (DVT/PE) during the coronavirus pandemic 2020
https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Coronavirus/FINAL%20Guidance%20on%20safe%20switching%20of%20warfarin%20to%20DOAC%20COVID-19%20Mar%202020.pdf?ver=2020-03-26-180945-627