Warfarin Management CPG – Ambulatory Appendix A: Warfarin Management Dosing Tool – Adult – Ambulatory

Warfarin Initiation Dosing Protocol (Week 1) **with INR Goal 2-3**

Day Therapy	INR Value	Total Daily Dose
Day 1		5 mg daily (2.5 mg daily for high sensitivity)
In 2-3 days after initiation	< 1.5 1.5-1.9 2.0-2.5 > 2.5	5 – 7.5 mg daily 2.5 - 5 mg daily 2.5 mg daily Hold and recheck INR next day
In additional 2-3 days after last INR check	< 1.5 1.5-1.9 2.0-3.0 > 3.0	7.5 – 10 mg daily 5 – 10 mg daily 2.5 – 5 mg daily Hold warfarin, recheck in 1-2 days

Frequency of INR Monitoring After Initiation of Warfarin

Check INR	
Every 2 – 3 days	Until INR within therapeutic range on 2 consecutive INR checks
Then every week	Until INR within therapeutic range on 2 consecutive INR checks
Then every 2 weeks	Until INR within therapeutic range on 2 consecutive INR checks
Then every 4 weeks	When dose is stable check monthly

Frequency of INR Monitoring for Maintenance of Warfarin

Check INR	
After 3-5 days	If start/stop interacting medication, change in diet, change in activity level or other change that could affect INR
Every 1-2 weeks	If dose needed adjustment by 5-10%
Every 4 weeks	If maintained on same stable dose < 6 months
Every 6-8 weeks	If maintained on same stable dose for at least 6 months

Warfarin Maintenance Dosing Protocol with INR Goal 1.5 – 2.0

INR ≤ 1.2	INR 1.3 -1.4	INR 1.5 - 2.0	INR 2.1 – 3.0	INR 3.1 - 4.0*	INR 4.1-5.0*	INR 5.1-9.0*	INR > 9.0
Increase weekly dose 10%	Increase weekly dose 5%	No change	Decrease weekly dose 5%	Consider half dose x 1 Decrease weekly dose 10%	Hold 1 dose Decrease weekly dose by 10-20%	**MD order required**: Hold 2 doses Decrease weekly dose 10-20%	Contact MD for urgent patient evaluation

* If the INR is above the specified range for accuracy per POC device, a repeat venipuncture is required to verify INR

Warfarin Maintenance Dosing Protocol with INR Goal 2-3

INR < 1.5	INR 1.5 - 1.9	INR 2.0 - 3.0	INR 3.1- 4.0*	INR 4.1-5.0*	INR 5.1- 9.0*	INR > 9.0
Extra Dose Increase weekly dose 10-20%	Increase weekly dose 5-10%	No change	Decrease weekly dose 5-10%	Hold 1 dose Decrease weekly dose 10%	**MD order required** Hold 2 doses Decrease weekly dose 10-20%	Contact MD for urgent patient evaluation

* If the INR is above the specified range for accuracy per POC device, a repeat venipuncture is required to verify INR

Warfarin Maintenance Dosing Protocol with INR Goal 2.5-3.5

INR < 1.9ŧ	INR 1.9 - 2.4ŧ	INR 2.5 - 3.5	INR 3.6 - 4.5*	INR 4.6-5.0*	INR 5.1- 9.0*	INR > 9.0
Extra Dose Increase weekly dose 10-20%	Increase weekly dose 5-10%	No change	Decrease weekly dose 5-10%	Hold 1 dose Decrease weekly dose 10%	**MD order required** Hold 2 doses Decrease weekly dose 10-20%	Contact MD for urgent patient evaluation

* If the INR is above the specified range for accuracy per POC device, a repeat venipuncture is required to verify INR

ŧ If the INR < 2.0 and the patient has a mechanical valve then bridge therapy with a low molecular weight heparin should be considered

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Dosing Tips:

- If INR is above or below therapeutic range ≤ 0.5 and previously stable or there is a specific temporary reason for INR to be out of range (ex. missed dose): then continue current dose and test INR in 1-2 weeks
- If indicated a partial to full extra dose or partial to full held dose can be utilized based on INR and patient's sensitivity to warfarin
- Do not include extra or hold doses as part of a weekly dose adjustment
- Weekly warfarin doses ≥ 50 mg per week:
  - Smaller weekly dose adjustments should be targeted
  - *Include* extra or hold doses into the weekly dose adjustments
  - If an extra dose is indicated, avoid a full extra dose. Instead consider an extra half dose.

Drug Interactions: most drug interactions affect the INR within 3-5 days of concomitant therapy

Drug Interaction	Weekly Warfarin Dose Adjustment	Recheck INR
Fluconazole Metronidazole Sulfamethoxazole/trimethoprim	Day 1 of interaction: Decrease weekly warfarin dose by 30%	3 - 5 days
Amiodarone	Day 7 of amiodarone: Decrease weekly warfarin dose by 25% Day 14 of amiodarone: Decrease weekly warfarin dose by another 25% *Target a 50% reduction in weekly warfarin dose after 2 weeks of dual therapy.*	After 7 days of dual therapy After 14 days of dual therapy After 21 days of dual therapy (if INR within goal then follow maintenance INR monitoring table)
Rifampin	Day 7 of rifampin: Increase weekly warfarin dose by 25% Day 14 of rifampin: Increase weekly warfarin dose by another 25% *Target a 50% increase in weekly warfarin dose after 2 weeks of dual therapy.*	After 7 days of dual therapy After 14 days of dual therapy After 21 days of dual therapy (if INR within goal then follow maintenance INR monitoring table)
All other drug interactions	Adjust weekly warfarin dose if INR outside of therapeutic range after INR recheck	3 – 5 days

Progress Note Documentation:

- ".Anticoagplan" – use for documenting warfarin management plan
- ".Anticoagassess" – use for documenting patient findings (positive/negative) table
- ".Anticoagmessage" – use for documenting when unable to reach a patient

Anticoagulation Episode of Care Workflows

- To create a new episode use the "Enroll in Anticoagulation" order (found in order entry)
- Resolve the episode using the "discontinue therapy" button in the tracking section when a patient discontinues warfarin therapy, transfers care outside of UW Health or is deceased.
- If a patient transfers care within UW Health, the receiving clinic must resolve the current episode and re-enter a new Enroll in Anticoagulation order to reactivate the episode with their clinic specific information.

Discontinuing Warfarin

When warfarin therapy is discontinued completed the following check list:

- ✓ Resolve the episode using the "discontinue therapy" button in the tracking section
- ✓ Check for open orders related to monitoring warfarin (ex – INR) and discontinue
- ✓ Medication list – remove warfarin from the patient's medication list
- ✓ Problem list – remove any problems related to managing warfarin (ex. long-term monitoring of anticoagulants)