An AC Forum Rapid Resource

Presenters:

Allison Burnett, PharmD | Steve Deitelzweig, MD, MMM Scott Kaatz, DO, MSc | Ronni Nemeth, PharmD, CACP, DPLA

Presenters



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- Lead Inpatient Antithrombosis Stewardship Pharmacist, University of New Mexico Hospital
- Associate Clinical Professor, University of New Mexico, College of Pharmacy



Scott Kaatz, DO, MSc, SFHM

- Clinical Professor of Medicine, Wayne State University School of Medicine
- Senior Staff Hospitalist, Medical Director for Professional Development and Research, Division of Hospital Medicine, Henry Ford Hospital



Steve Deitelzweig, MD, MMM

- System Chairman for Hospital Medicine and Medical Director of Regional Business Development, Ochsner Health System
- Professor of Medicine, Ochsner Health System/University of Queensland



Ronni Nemeth, PharmD, CACP, DPLA

- Manager, Anticoagulation Clinics, Confluence Health
- Co-chair of Confluence Health Anticoagulation Steering Committee

Disclosures & Notification of Support

Acknowledgement of Financial Commercial Support:

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The below speaker disclosure has the listed relevant financial relationships with commercial interests:

Scott Kaatz, DO, MSc

Bristol-Myers Squibb (BMS) | Osmosis | Janssen Pharmaceuticals | Pfizer Pharmaceuticals Inc | Novartis | Portola/Alexion Pharmaceuticals | Gilead Sciences

Steve Deitelzweig, MD, MMM

Portola/Alexion Pharmaceuticals | Bristol-Myers Squibb (BMS) | Pfizer Pharmaceuticals Inc

Background and Scope

- In 2008 the surgeon general issued a Call to Action to prevent DVT and PE and recognized VTE as a significant public health concern.¹
- In 2020, the American Heart Association issued a Call to Action for better implementation of VTE risk stratification, prevention, and tracking.²
- Up to 70-80% of VTE events occur after hospital discharge with length of stay being much shorter now than in seminal studies that used 6-14 days of LMWH.³

VTE in Medically III Patients

- Half of VTE events occur due to hospital admission for surgery (24%) or medical illness (22%)
- Risk factors for VTE in hospital include cancer, advanced age, prior VTE, central lines, immobility
- 40% of hospitalized patients have 3 or more risk factors for VTE
- Increase in thrombosis risk in medical inpatients persists 45-60 days after discharge

CY 2021 VTE-1 and VTE-2 eCQMs

Assesses the number of hospitalized adult patients who received VTE prophylaxis (pharmacological or mechanical prophylaxis), or have documentation why no VTE prophylaxis was given for:

- VTE-1: The day of or the day after (1) hospital admission; or (2) the surgery end date for surgeries that start the day of or the day after hospital admission
- VTE-2: The day of or the day after (1) the initial admission (or transfer) to the ICU; or
 (2) surgery end date for surgeries that start the day of or the day after ICU admission or transfer

Updates: CMS updated VTE-1 and 2 logic to include rivaroxaban as approved medication administration for VTE prophylaxis in medically ill patients as it has FDA approval













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BOTTOM LINE

DON'T

· Use bleeding risk · Do not use

CONSIDER

CAUTION · This information is based on expert opinion in

 Do not give all patients VTE pro-phylaxis indiscrim-inately without risk + Extended post-discharge VTE prophylaxis in appropriate patients (see oriteria below)⁵

the absence of robust data Some patients will be appropriate for a different

prophylaxis in medically ill

combined pharmacologic and mechanical

· Use mechanical In 2008 the surgeon general issued a Call to Action to prevent DVT and PE and recognized VTE as a significant prophylaxis in patients with high VTE risk and high public health concern.1

 Use low molecu-- Use low moscu-lar weight heperin 1 MWH) instead countractionated he, yin (UFH) in particle with

bleeding risk^a

Use VTE risk

assessment at ad-mission, through-out hospitalization,

and at discharge³

logic prophylaxis

in patients with high VTE risk and acceptable bleeding risk⁸

> Hospitalized non-surgical medically and critically ill patiers Considerations for extended duration thromboprophy (EDT) among high risk medically ill patients at disa

In 2020, the American Heart Association issued a call to action for better implementation of VTE risk stratification,

Pharmacologic Dosing Options

prevention and tracking.2

Enoxaparin Oten deed Deeles 40mm CC once dally

	Standard Dosing	40mg SC once daily
•	CrCl <30mL/min	30mg SC once daily
	CrCl <20mL/min	Avoid use
	Obese patients (BMI > 40kg/m²)	40 mg BID 60mg BID (BMI >47kg/m ²) ^{6,1} 0.5mg/kg QD ⁸

Dalteparin

Standard Dosing	5000 units SC once daily
CrCl <30mL/min	Avoid use
Obese patients (BMI > 40kg/m²)	7500 units SC once daily ^{10,11}

Unfractionated Heparin (UFH)

Standard Dosing	5000 units SC 8-12 hours
Obese patients	7500 units BID-TID* 9.10
(BMI>40kg/m2)	"Evidence is limited.

Fondaparinux

Standard Dosing 2.5mg SC once daily (pt wt ≥50kg)

Wt <50 kg or Avoid use CrCL< 30 mL/min

Rivaroxaban*

Standard Dosing 10mg once daily continued (Extended Duration) for 31-39 days total

"Indicated for use during hospitalization and post-hospital discharge in adults admitted for an aguse medical linear who are at risk for thromboemboils." complications due to moderate or severe restricted mobility and other risk factors for VTE and not at high risk of bleeding (refer to criteria chart)

Gockcroft-Gault should be used to calculate CrCl

Examples of Risk Assessment Models⁴

Several VTE risk assessment models (RAMs) exist, none of which have been extensively studied in impact analysis. As such, contemporary guidelines do not give preference to any single RAM. Rather, it is suggested to use a validated RAM to assess both VTE risk and bleeding risk to identify patients who are (and who are not) at sufficient risk for prophylaxis and preferred treatment modality (pharmacologic vs mechanical)3.

Padua VTE: Low risk: 0-3 High risk: ≥4		IMPROVE VTE 7: Low risk: 0-1 High risk: ≥2		IMPROVE VTE 4: Low risk: 0-1 High risk: ≥2		IMPROVE Blood Low risk: <7 High risk: ≥7	ng:
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A live cancer	3	Known thrombophilia	2	Malignancy (treated or untreated w/in 6 months)	1	Current cancer	2
Fevious VTE	3	Lower limb paralysis	2	Thrombophilia	3	Rheumatic disease	2
Known thrombophilic condition	3	Active cancer	2	Age >60 yrs	1	Central venous catheter	2
Recent trauma and/or surgery (<1mo)	2	Immobilization ≥7	7d 1			ICU/CCU stay	2.5
Elderly age (>70yr)	1	ICU/CCU stay	1			Hepatic failure (INR>1.5)	2.5
Heart and/or respiratory failure	1	Age >60yr	1			GFR <30 mL/min/m²	2.5
Acute MI or ischemic stroke	1					GFR 30-59 mL/min/m²	1
Ongoing hormonal tx	1					Age 40-84 yr	1.5
Obesity (BMI>30)	1					Age ≥ 85yr	3.5
Acute infection and/or rheuma- tologic disorder	1					Gastro- duodenal ulcer	4.5
						Bleeding in prior 3 months	4
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Extended Duration Thromboprophylaxis (EDT)⁵

Rationale: Up to 70-80% of VTE occur after hospital discharge.

Length of stay is now much shorter than in seminal studies that utilized 6-14 days of LMWH7

The following criteria pertain to rivaroxaban, which is currently the only commercially available, FDA-approved agent for EDT.

Consider rivaroxaban 10 mg PO daily for a total of up to 39 days in patients who meet selection criteria below:

For patients aged >60 and hospitalized for ≥1 of the following acute medical conditions: Decompensated heart failure • Respiratory insuffiency or COPD exacerbation • Infectious or inflammatory disease

Ischemic stroke with lower extremity paresis and reduced mobility

For patients aged 40-59, hospitalized for ≥ 1 of the above acute medical illnesses AND Have history of prior VTE or active cancer AND ≥1 of the below additional VTE risk factor(s): Previous VTE or superficial vein thrombosis • History of NYHA Class III or IV HF • Concomitant acute infection Obesity (BMI >35) . History of cancer . Inherited or acquired thrombophilia Current use of erythropoiesis-stimulating agent . Hormone therapy

Exclusion Criteria:

Contraindications to anticoagulant prophylaxis . Creatinine Clearance <30mL/min Concomitant combined P-gp and strong CYP3A4 inhibitors and inducers • Pregnant or breastfeeding Currently on dual antiplatelet therapy (DAPT) . Active bleeding within the last 3 months Gastroduodenal ulcers within the last 3 months

History of bronchiectasis, pulmonary cavitation, or pulmonary hemorrhage Active cancer (undergoing acute in-hospital cancer treatment)

*Bolded exclusion criteria have been linked to increased fatal or major bleeding events⁵

References: 1. Office of the Surgaco Garanti ASS; 2006. PMID: 20080525. 2. Herika PK. Circulation. 2000. PMID: 23287490. 3. Schönermen HJ. Blood Adv. 2016. PMID: 30482783. 4. Berkousish E. Am.J. Mad. 2020. PMID: 23282498. 8. Spyropoulis AG. (cil. Appl Throne Hermat.) 2019. PMID: 3748218 5. Berlagua-Cleaniek MJ. Surg Otea Relate Lib. 2009. PMID: 1581985. 7. Am.n MJ. J. Hosp Med. 2012. PMID: 25190427. 8. Rondina MT. Thromb Res. 2010. PMID: 15827855 5. Semual S. J. Thromb Thrombolysis. 2015. PMID: 25739856. 10. Strellf MB. J. Hall Compr Cano Neiw. 2015. PMID: 26398792. 11. Simoneau MD. Obes Surg. 2010. PMID: 15891858. 7. Obes Surg. 2010. PMID: 15891858. 7. Am. 2015. PMID: 1589185. 7. Am. 2015. PM

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BOTTOM LINE

DO	DON'T	CONSIDER	CAUTION
 Use VTE risk assessment at admission, throughout hospitalization, and at discharge³ Use bleeding risk assessment³ Use pharmacologic prophylaxis in patients with high VTE risk and acceptable 	 Do not give all patients VTE prophylaxis indiscriminately without risk assessment Do not use combined pharmacologic and mechanical prophylaxis in medically ill patients³ 	• Extended post-discharge VTE prophylaxis in appropriate patients (see criteria below) ⁵	 This information is based on expert opinion in the absence of robust data Some patients will be appropriate for a different approach
 Use mechanical prophylaxis in patients with high VTE risk and high bleeding risk³ Use low molecular weight heparin (LMWH) instead of unfractionated heparin (UFH) in patients with adequate renal function³ 	prevent DVT and P public health conce In 2020, the Americ action for better imp prevention and trac Scope: Hospitalized non-se Considerations for	an Heart Association i	as a significant ssued a call to sk stratification, critically ill patients comboprophylaxis

Case Part 1

65-year-old admitted to the medical ward for CHF exacerbation No history of VTE, cancer or thrombophilia Normal renal and liver function No increased bleeding risk Normal weight COVID-19 negative

Would you prescribe VTE prophylaxis?

- a) Yes
- b) No









ANTICOAGULATION Centers of Excellence

Venous Thromboembolism (VTE) Prophylaxis in Acutely III Medical Patients

CAUTION

This information

is based on expert opinion in the absence of

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appropriate for a different

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BOTTOM LINE

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Hospitalized non-surgical medically and critically ill patients Considerations for extended duration thromboprophylaxis

(EDT) among high risk medically ill patients at discharge

DO DON'T CONSIDER Do not give all patients VTE pro-phylaxis indiscrim-inately without risk · Use VTE risk + Extended assessment at ad-mission, through-out hospitalization, post-discharge VTE prophylaxis in appropriate patients (see and at discharge³ criteria below/ · Use bleeding risk + Do not use combined pharmacologic and mechanical logic prophylaxis prophylaxis in medically ill in patients with high VTE risk and acceptable bleeding risk⁸ Use mechanical In 2008 the surgeon general issued a Call to Action to prevent DVT and PE and recognized VTE as a significant prophylaxis in patients with high VTE risk and high public health concern.1 oleeding risk^a In 2020, the American Heart Association issued a call to

prevention and tracking.2

Pharmacologic Dosing Options

 Use low molecular weight heperin (LMWH) instead of unfractionaled

heparin (UFH) in patients with

adequate renal function³

Standard Dosir

CrCL< 30 mL/min

Enoxaparin				
Standard Dosing	40mg SC once daily			
CrCl <30mL/min	30mg SC once daily			
CrCl <20mL/min	Avoid use			
Obese patients (BMI > 40kg/m²)	40 mg BID 60mg BID (BMI >47kg/m ² / ^{6,15} 0.5mg/kg QD ⁶			

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active cancer	3	Known thrombophilia	2	Malignancy (treated or untreated w/in 6 months)	1	Current cancer	2
Previous VTE	3	Lower limb paralysis	2	Thrombophilia	3	Rheumatic disease	2
Known thrombophilic condition	3	Active cancer	2	Age >60 yrs	1	Central venous catheter	2
Recent trauma and/or surgery (<1mo)	2	Immobilization ≥7	'd 1	_		ICU/CCU stay	2.5
Elderly age (>70yr)	1	ICU/CCU stay	1			Hepatic failure (INR>1.5)	2.5
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Low Risk: Do not requi High Risk: Should rece High Bleeding Risk: Mi	ive in-h	ospital prophylaxis4				Admission platelets <50,000	

Extended Duration Thromboprophylaxis (EDT)5

Rationale: Up to 70-80% of VTE occur after hospital discharge.

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Risk Factor	Score	Risk Factor	Score	Risk Factor	Score	Risk Factor	Score
Reduced mobility	3	Previous VTE	3	Previous VTE	3	Male	1
Active cancer	3	Known thrombophilia	2	Malignancy (treated or untreated w/in 6 months)	1	Current cancer	2
Previous VTE	3	Lower limb paralysis	2	Thrombophilia	3	Rheumatic disease	2
Known thrombophilic condition	3	Active cancer	2	Age >60 yrs	1	Central venous catheter	2
Recent trauma and/or surgery (<1mo)	2	Immobilization ≥7	d 1			ICU/CCU stay	2.5
Elderly age (>70yr)) 1	ICU/CCU stay	1			Hepatic failure (INR>1.5)	2.5
Heart and/or respiratory failure	1	Age >60yr	1			GFR <30 mL/min/m ²	2.5
Acute MI or ischemic stroke	1					GFR 30-59 mL/min/m ²	1
Ongoing hormonal to	x 1					Age 40-84 yr	1.5
Obesity (BMI>30)	1					Age ≥ 85yr	3.5
Acute infection and/or rheumatologic disorder	1					Gastro- duodenal ulcer	4.5
						Bleeding in prior 3 months	4
Low Risk: Do not requ High Risk: Should rec	eive in-h	ospital prophylaxis4				Admission platelets <50,000	4

High Bleeding Risk: Might indicate preference for mechanical prophylaxis while bleeding is high: reassessment is warranted4

Case Part 1

65-year-old admitted to the medical ward for CHF exacerbation No history of VTE, cancer or thrombophilia Normal renal and liver function No increased bleeding risk Normal weight COVID-19 negative

What would you do for VTE prophylaxis?

- a) Heparin 5000 units SQ tid
- b) Enoxaparin 40 mg SQ daily
- c) Pneumatic compression devices
- d) No prophylaxis needed











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BOTTOM LINE

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DO	DON'T	CONSIDER	CAUTION
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Fondaparinux

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Avoid use Rivaroxaban*

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Pharmacologic Dosing Options

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Rivaroxaban*

Standard Dosing 10mg once daily continued (Extended Duration) for 31-39 days total

*Indicated for use during hospitalization and post-hospital discharge in adults admitted for an acute medical illness who are at risk for thromboembolic complications due to moderate or severe restricted mobility and other risk factors for VTE and not at high risk of bleeding (refer to criteria chart)

Cockcroft-Gault should be used to calculate CrCl

Case Part 2

After 3 days in the hospital, the patient develops pneumonia, sepsis and requires intubation and mechanical ventilation.

Would you prescribe VTE prophylaxis?

- a) Yes
- b) No

What would you do for VTE prophylaxis?

- a) Heparin 5000 units tid
- b) Enoxaparin 40 mg daily
- c) Pneumatic compression
- d) No prophylaxis needed

They are extubated and discharged from ICU 5 days later back to the floor. Kidney and liver function are normal

Would you prescribe VTE prophylaxis?

- a) Yes
- b) No

What would you do for VTE prophylaxis?

- a) Heparin 5000 units tid
- b) Enoxaparin 40 mg daily
- c) Pneumatic compression
- d) No prophylaxis needed

Case 3

3 days after returning to the floor the patient is ready for discharge, CHF and pneumonia are improved.

Patient is weak but does not require physical therapy.

Would you prescribe extended-duration prophylaxis EDT?

- a) Yes
- b) No











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BOTTOM LINE

DO	DON'T	CONSIDER	CAUTION
ь	DON'T	CONSIDER	CAUTION
Use VTE risk assessment at admission, throughout hospitalization, and at discharge? Use bleeding risk assessment? Use pharmacologic prophylaxis in pasants with high VTE risk and acceptable bleeding risk?	Do not give all patients VTE pro- phylacis indiscrim- inately without risk assessment Do not use combined pharmacologic and mechanical prophylacis in medically ill patients ²	Extended post-discharge VTE prophylaxis in appropriate patients (see oriteria below) ⁶	This information is based on expert opinion in the absence of robust data Some pasents will be appropriate for a different approach
Use mechanical prophylaxis in patients with high VTE risk and high bleading risk? Use low molecular weight hoperin (LMWH) instead of unfractionated haparin (UFH) in patients with adequate renal.	prevent DVT and F public health conc in 2020, the Americ action for better im prevention and trac Scope: Hospitalized non-s	an Heart Association plementation of VTE oking. ² urgical medically and extended duration the	E as a significant issued a cell to isk stratification, critically ill patients romboprophylaxis

Pharmacologic Dosing Options

Enoxaparin			
Standard Dosing	40mg SC once daily		
CrCl <30mL/min	30mg SC once daily		
CrCl <20mL/min	Avoid use		
Obese patients (BMI > 40kg/m²)	40 mg BID 60mg BID (BMI >47kg/m ³) ^{6,12} 0.5mg/kg QD ⁶		
n	altenarin		

Standard Dosing	5000 units SC once daily			
CrCl <30mL/min	Avoid use			
Obese patients (BMI > 40kg/m²)	7500 units SC once daily ^{10,11}			

Unfractionated Heparin (UFH)

Standard Dosing	5000 units SC 8-12 hours
Obese patients	7500 units BID-TID* 9.10
(BMI>40kg/m2)	"Evidence is limited.

Fondaparinux

Standard Dosing (pt wt ≥50kg)	2.5mg SC once daily	\
Wt <50 kg or CrCL< 30 mL/min	Avoid use	
Riv	varoxaban*	

Standard Dosing 10mg once daily continued (Extended Duration) for 31-39 days total

"Indicated for use during hospitalization and post-hospital discharge in adults admitted for an early medical linear who are at risk for thermboarhootic complications due to moderate or severe nethrical mobility and other field factors for VTB and not at high disk of bleeding (when to obtains chart).

Gockcroft-Gault should be used to calculate CrCl

Examples of Risk Assessment Models⁴

Several VTE risk assessment models (RAMs) exist, none of which have been extensively studied in impact analysis. As such, contemporary guidelines do not give preference to any single RAM. Rather, it is suggested to use a validated RAM to assess both VTE risk and bleeding risk to identify patients who are (and who are not) at sufficient risk for prophylaxis and preferred treatment modality (pharmacologic vs mechanical)5.

Padua VTE: Low risk: 0-3 High risk: ≥4		IMPROVE VTE 7: Low risk: 0-1 High risk: ≥2		IMPROVE VTE 4: Low risk: 0-1 High risk: ≥2		IMPROVE Bloodi Low risk: <7 High risk: ≥7	ing:
Risk Factor	Score	Risk Factor	Score	Risk Factor	Score	Risk Factor	Score
Reduced mobility	3	Previous VTE	3	Previous VTE	3	Male	1
Active cancer	3	Known thrombophilia	2	Malignancy (treated or untreated w/in 6 months)	1	Current cancer	2
Previous VTE	3	Lower limb paralysis	2	Thrombophilia	3	Rheumatic disease	2
Known thrombophilic condition	3	Active cancer	2	Age >60 yrs	1	Central venous catheter	2
Recent trauma and/or surgery (<1mo)	2	Immobilization ≥7	d 1			ICU/CCU stay	2.5
Elderly age (>70yr)	1	ICU/CCU stay	1			Hepatic failure (INR>1.5)	2.5
Heart and/or respiratory failure	1	Age >60yr	1			GFR <30 mL/min/m²	2.5
Acute MI or ischemic stroke	1					GFR 30-59 mL/min/m²	1
Ongoing hormonal t	x 1					Age 40-84 yr	1.5
Obesity (BMI>30)	1					Age ≥ 85yr	3.5
Acute infection and/or rheuma- tologic disorder	1					Gastro- duodenal ulcer	4.5
						Bleeding in prior 3 months	4
Low Risk: Do not requ	ire prop	hylaxis4 cate preference for med				Admission platelets < 50,000	4

<u>extended Duration Thromboprophylaxis</u> (ED)

Rationale: Up to 70-80% of VTE occur after hospital discharge. gth of stay is now much shorter than in seminal studies that utilized 6-14 days of Liv

criteria pertain to rivaroxaban, which is currently the only commercially available, FDA-approve

rivaroxaban 10 mg PO daily for a total of up to 39 days in patients who meet selection crite

For patients aged >60 and hospitalized for ≥1 of the following acute medical conditions: pensated heart failure • Respiratory insuffiency or COPD exacerbation • Infectious or inflammatory of

Ischemic stroke with lower extremity paresis and reduced mobility

For patients aged 40-59, hospitalized for ≥ 1 of the above acute medical illnesses AND Have history of prior VTE or active cancer AND ≥1 of the below additional VTE risk factor(s): ious VTE or superficial vein thrombosis . History of NYHA Class III or IV HF . Concomitant acute infection Obesity (BMI >35) . History of cancer . Inherited or acquired thrombophilia Current use of erythropoiesis-stimulating agent . Hormone therapy

Exclusion Criteria:

Contraindications to anticoagulant prophylaxis . Creatinine Clearance <30mL/min Concomitant combined P-gp and strong CYP3A4 inhibitors and inducers • Pregnant or breastfee Currently on dual antiplatelet therapy (DAPT) . Active bleeding within the last 3 months Gastroduodenal ulcers within the last 3 months

History of bronchiectasis, pulmonary cavitation, or pulmonary hemorrhage Active cancer (undergoing acute in-hospital cancer treatment)

exclusion criteria have been linked to increased fatal or major bleed

References: 1, Office of the Surgeon General (AS), 2006, PMID: 20560555. 2, Harina PK. Cisculation, 2005, 1983, 2027,5403, 3, Schlammer HJ. Blood Any, 2016, Bid. 20462783, 4, Barkoushi E. Am.) Med. 2005, PMID: 2056048. 6, Spripposion Act, Coll Appl Thronthe Herral, 2019, HIND: 3746215 6, Bidnight St. 2019, 1987, 1989, 2019, 1987, 4019, 2019, 1987, 2019, 1987, 2019, 1987, 2019, 1987, 2019, 1987, 2019, 1987, 2019, 1987, 2019

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Extended Duration Thromboprophylaxis (EDT)⁵

Rationale: Up to 70-80% of VTE occur after hospital discharge.

Length of stay is now much shorter than in seminal studies that utilized 6-14 days of LMWH⁷

The following criteria pertain to rivaroxaban, which is currently the only commercially available, FDA-approved agent for EDT.

Consider rivaroxaban 10 mg PO daily for a total of up to 39 days in patients who meet selection criteria below:

For patients aged >60 and hospitalized for ≥1 of the following acute medical conditions:

Decompensated heart failure • Respiratory insuffiency or COPD exacerbation • Infectious or inflammatory disease Ischemic stroke with lower extremity paresis and reduced mobility

OR

For patients aged 40-59, hospitalized for ≥ 1 of the above acute medical illnesses AND Have history of prior VTE or active cancer AND ≥1 of the below additional VTE risk factor(s):

Previous VTE or superficial vein thrombosis • History of NYHA Class III or IV HF • Concomitant acute infection Obesity (BMI >35) • History of cancer • Inherited or acquired thrombophilia Current use of erythropoiesis-stimulating agent • Hormone therapy

Exclusion Criteria:

Contraindications to anticoagulant prophylaxis • Creatinine Clearance <30mL/min
Concomitant combined P-gp and strong CYP3A4 inhibitors and inducers • Pregnant or breastfeeding
Currently on dual antiplatelet therapy (DAPT) • Active bleeding within the last 3 months
Gastroduodenal ulcers within the last 3 months
History of bronchiectasis, pulmonary cavitation, or pulmonary hemorrhage
Active cancer (undergoing acute in-hospital cancer treatment)

*Bolded exclusion criteria have been linked to increased fatal or major bleeding events5

Anticoagulation Stewardship Considerations

- Confirmation of access to medication (e.g., insurance coverage)
- Clear documentation of a finite duration of therapy
- Education and empowerment of patient/family on appropriate use

AC Forum Resource-Order Set

Anticoagulation Forum - VTE prophylaxis for the medically ill patient Order Set, March 2020

Updated by AC Forum 3/2020, this order set is intended to facilitate standardized venous thromboembolism (VTE) prophylaxis risk stratification of hospitalized medically ill patients for: Hospital-acquired VTE, prophylaxis-associated bleeding on anticoagulation administration and prescription of risk-appropriate VTE prophylaxis

VTE Prophylaxis for the Medically III Patient (Updated 2020)

Administration

DOCUMENT PURPOSE

This order set is intended to facilitate standardized venous thromboembolism (VTE) prophylaxis risk stratification of hospitalized medically ill patients for:

- Hospital-acquired VTE
- Prophylaxis-associated bleeding on anticoagulation administration
- Prescription of risk-appropriate VTE prophylaxis



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