Anticoagulation Guidelines for Warfarin

Please note this is a guideline for healthcare professionals to utilize when dosing inpatient warfarin. As a guideline, it gives general information for managing warfarin, but all final dosing decisions are made by the provider based on their clinical judgment subject to the condition being treated and to the potential for medication interactions.

INR Goal Range (specific goal range is subject to the provider's final decision)

2.5 - 3.5: mechanical prosthetic heart valves, antiphospholipid syndrome with risk factors, or recurrent VTE

2 - 3: DVT/PE, A. Fib, tissue heart valves, orthopedic surgery PX, cardiomyopathy

Initial Dose of Warfarin

Men & Women: 5 – 7.5 mg

IF patient is younger, heavier and has no interacting medications, consider using larger initial doses (i.e. 7.5 mg, possibly 10 mg in some patients)

Consider using lower initial doses (i.e. 2.5 mg) in frail elderly patients, malnourished, and patients with known clinically significant disease-drug or drug-drug interactions (i.e. Flagyl, Bactrim, Diflucan, Amiodarone, decompensated CHF, etc.)

Patients Previously on Warfarin

In range: Use home dose
Low: Consider 25-75% one day increase
High: Consider 25-75% one day decrease

Second Dose of Warfarin

Give same dose as day before
* *If INR increases ≥ 0.4 after the first dose, consider holding or decreasing the dose by 25-50% (may indicate patient sensitive to warfarin)*

Third/Ensuing Doses of Warfarin

If after two days of the same dose and: < 0.3 increase in INR, consider increasing the dose 25-50%
0.3 – 0.5 increase in INR, consider giving the same dose
> 0.5 – 1.5 increase in INR after two days, consider decreasing dose by 25-75%

Dosing When INR in Range

- How many mg's of warfarin did the patient require to get therapeutic?
  example: 21 mg total of warfarin for patient to achieve therapeutic INR = approx daily maint dose of 3 mg per day (21÷7 = 3)
- How will the clinical conditions of the patient or interacting medications affect the INR?

When to Hold Warfarin

Consider holding if INR: > 1.5 increase in INR in 1 day, regardless of INR value
≥ 3.5 (if goal INR 2 – 3)
≥ 4 (if goal INR 2.5 – 3.5)

** please see Vitamin K guidelines if patient is over anti-coagulated or in need of an emergent invasive procedure*

Significant Drug Interactions:

Increase the INR: amiodarone, Flagyl, Diflucan, Bactrim, Cipro, VFend, Sporanox, alcohol (acute ingestion)
* consider 50% increase in patient's usual dose when interacting medications started

Decrease the INR: barbiturates, carbamazepine, griseofulvin, phenytoin, rifampin, foods high in vitamin K, tube feeding (binding interaction)

Risk Factors for warfarin sensitivity and/or increased risk of bleeding:

Decompensated CHF, recent surgery, Hct < 30, Age > 60, Albumin < 3 / malnutrition, active liver disease, elevated baseline INR (1.2-1.5)