AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

NSQHS STANDARDS

GUIDANCE
for health service organisations

Position Statement

Management of patients on oral anticoagulants during COVID-19

Position

Management of patients who are on oral anticoagulants and who display COVID-19 symptoms needs special consideration due to the risk of coagulopathies – recommend haematologist involvement.

Where patients are well, but need regular anticoagulant blood monitoring consider flexible management approaches during periods of self-isolation or quarantine – review with usual prescriber.

Background

There is some evidence to suggest that anticoagulation therapy with low molecular weight heparins (LMWH) appears to be associated with better prognosis in patients with moderate to severe COVID-19 sepsis induced coagulopathies or elevated D-dimer results.[1, 2]

There is currently no evidence to suggest how clotting may be affected in patients with mild disease. Living guidelines for the anticoagulant management of inpatients infected with COVID-19 are available on the **National COVID-19 Clinical Evidence Task Force website**.

Patients prescribed a direct acting oral anticoagulant (DOAC) or warfarin should continue their usual therapy unless otherwise advised by their prescriber.

Patients, who present with COVID-19 symptoms and need management in hospital, may have their oral anticoagulation switched to an alternative agent based on specialist advice.[3]

Patients prescribed warfarin in the community setting who require ongoing Internationalised Normalised Ratio (INR) monitoring, may find it harder to have their blood taken during COVID-19 because of social distancing and quarantine rules.

Strategies to minimise this impact may include:

- Taking or testing blood from the patient at home especially where a patient has COVID-19 like symptoms. Utilising point-of-care / in home INR testing could be considered where available.
- Extending the INR monitoring interval, up to 6 weeks or longer, between INR tests for patients who have demonstrated good INR control and have achieved a time-in-target (TTR) of >60 and are currently well.[4]
- Advising patients to attend pathology clinics during quieter periods, to support social distancing and avoid attending if they have COVID-19 like symptoms. Additionally as most patients taking oral anticoagulants show at least one comorbid condition, patients attending pathology clinics should be advised to to use **face masks**, **practise social distancing and good hand hygiene** before, during and after the clinic visit.[5,6]
- Switching from warfarin to a DOAC may be a consideration. However, not all patients are suitable for a switch and specialist advice should be sought.[4,7,8]

Additional guidance on switching can be found on the specific DOAC Product Information Sheets for apixaban, dabigatran or rivaroxaban, hosted on the **TGA website**

Avoid switching from an oral anticoagulant to an antiplatelet drug, for example aspirin. This is not an effective equivalent to an anticoagulant.[4]

Summarised guidance on DOACs and support information for patients is published by some states and territories, noting these resources may be under review.

NSW Health – **Clinical Excellence Commission NOAC Guidelines**

SA Health – **Clinical Guideline: Safe prescribing of new oral anticoagulants: apixaban, rivaroxaban and dabigatran**

08/2020

WA Health – **Living with a direct-acting oral anticoagulant (DOAC) information for patients**

QLD Health – **Guideline for managing patients on a factor Xa inhibitor – Apixaban (Eliquis) or Rivaroxaban (Xarelto)**

Guidance for managing patients on dabigatran (Pradaxa)

References

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The Commission gratefully acknowledges review of this position statement by the Thrombosis and Haemostasis Society of Australia and New Zealand (THANZ) and the Australasian Society of Experimental Pharmacologists and Toxicologists (ASCEPT).

Date of revision: 27 August 2020

If you have feedback regarding this position statement, please email: **medsafety@safetyandquality.gov.au**