

ALLERGIES – SEE HMOF/ORCA

UW MEDICINE INPATIENT WARFARIN ORDER

NEW START CONTINUATION OF PRIOR THERAPY

TREATMENT PLAN complete prior to FIRST inpatient Warfarin dose AND on service transfer

Indication:

- DVT/PE/acute thromboembolism Prosthetic cardiac valve Valvular heart disease
- Dilated cardiomyopathy A. fib/A. flutter Tunneled apheresis catheter prophylaxis
- Other: _____ Primary VTE prevention (e.g. Orthopedic surgery) Long-term secondary VTE prevention (e.g. Hx recurrent thrombosis)

Diagnostic method (if DVT/PE/thromboembolism checked above):

- UE/LE duplex Date: _____ CT/CTA Date: _____
- Other: _____ (method) _____ (date) **(required if box checked)**

Target INR:

- 2-3 2.5-3.5 Other: _____

Anticipated duration of therapy:

- 3 months Lifelong/chronic Other: _____

LABORATORY MONITORING (REQUIRED)

- Baseline PT/INR and repeat daily **-OR-** Baseline PT/INR and repeat q _____ days
- Baseline CBC and repeat q _____ day(s) (*minimum suggested frequency is q3 days*)
- Refer to Bivalirudin orders for warfarin monitoring for patients on concurrent Bivalirudin therapy
- Notify MD if unable to obtain blood sample for PT/INR check

WARFARIN HISTORY

Today's INR value (required): _____

Last Warfarin dose (required): _____ mg on _____ (date) **-OR-** Dose not received ≥ 7 days

WARFARIN DOSING Complete each time a change in dose is indicated (start/increase/decrease/hold/discontinue)

Warfarin dose PO	Frequency (given at 1700)						
_____ mg	<input type="checkbox"/> Daily <input type="checkbox"/> Today only						
OR							
Alternating Warfarin dose PO daily at 1700	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
_____ mg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____ mg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OR							
<input type="checkbox"/> HOLD Warfarin x1 dose [RN TO DOCUMENT "NOT GIVEN" ON eMAR TASK]							
<input type="checkbox"/> DISCONTINUE Warfarin and <u>continue</u> PT/INR monitoring [NEW ORDER REQUIRED TO RESUME THERAPY]							
<input type="checkbox"/> DISCONTINUE Warfarin and <u>discontinue</u> PT/INR monitoring							

Refer to reverse for warfarin management resources

PHYSICIAN/PROVIDER SIGNATURE	PRINT NAME	PAGER	NPI	DATE	TIME
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PT.NO

NAME

DOB

UW Medicine
 Harborview Medical Center – UW Medical Center
 University of Washington Physicians
 Seattle, Washington

INPATIENT WARFARIN ORDERS



U2924

WHITE - MEDICAL RECORD

UW Medicine Warfarin Treatment Protocol:

- Patients treated with warfarin will have a documented Treatment Plan, including indication for therapy, target INR and anticipated duration of treatment
- Patients treated with warfarin will have a documented INR value on a daily basis (or documented rationale for its absence)
- Patients treated with warfarin will have routine monitoring of Hgb/Hct, platelet count and other clinical signs of bleeding complications
- Warfarin doses will be adjusted based on INR results, guided by clinical presentation and established Institutional guidelines (see below) by the primary service in consultation with the patient's designated clinical pharmacist

Factors that influence sensitivity to warfarin include: age >75, decompensated CHF, diarrhea, drug interactions, elevated baseline INR, fever/acute infection, hyperthyroidism, malignancy, malnutrition or NPO >3 days

Dosing Nomogram for INITIATION of Warfarin

Day	INR	5mg INITIATION
1	--	5 mg
2	<1.5	5 mg
	1.5-1.9	2.5 mg
	2-2.5	1-2.5 mg
3	>2.5	0
	<1.5	5-10 mg
	1.5-1.9	2.5-5 mg
	2-2.5	0-2.5 mg
	2.5-3	0-2.5 mg
4	>3	0
	<1.5	10 mg
	1.5-1.9	5-7.5 mg
	2-3	0-5 mg
5	>3	0
	<1.5	10 mg
	1.5-1.9	7.5-10 mg
	2-3	0-5 mg
6	>3	0
	<1.5	7.5-12.5 mg
	1.5-1.9	5-10 mg
	2-3	0-7.5 mg

- The 10mg initiation nomogram should only be used in relatively young and healthy patients who are likely to be insensitive to warfarin; for guidance on this method, please visit <http://uwmcacc.org/>

Dosing Nomogram for MAINTENANCE Therapy

Maintenance Therapy is defined as:

- Patient has a stable INR at the lower limit of therapeutic range
- Patient has been on a stable dose for at least 7 days

GOAL INR 2-3		GOAL INR 2.5-3.5
<2	Reload x0-1	<2.5
	Increase by 5-15%	
2-3	No change	2.5-3.5
3.1-3.5	Decrease by 0-15%	3.6-4
3.6-4	Hold 0-1 dose	4.1-4.5
	Decrease by 5-15%	
>4	Hold until therapeutic	>4.5

Commonly used Medications with MAJOR Warfarin Interactions (NOT AN INCLUSIVE LIST)	
Medication	Interaction
Amiodarone	↑ INR
Clarithromycin/Erythromycin	↑ INR
Trimethoprim/Sulfamethoxazole	↑ INR
Carbamazepine	↓ INR
Fluoxetine/Fluvoxamine	↑ INR
Ciprofloxacin/Levofloxacin	↑ INR
Fluconazole	↑ INR
Metronidazole	↑ INR
Phenytoin	↑ or ↓ INR
Rifampin/Rifabutin	↓ INR
Voriconazole	↑ INR

For more information, see Ansell J et al. Chest 2008; 133 (suppl 6): 166S

Guidelines for Correction of Warfarin Over-Anticoagulation

Adapted from Ansell J et al. Chest 2008; 133 (suppl 6): 160S-198S

INR	Clinical Settings	Therapeutic Options
<5	No bleeding	Hold warfarin until INR in therapeutic range +/- Vitamin K 2.5 mg PO
	Rapid reversal required	Hold warfarin and give Vitamin K 1 mg IV infusion or 2.5 mg PO
5-8.9	No bleeding	Hold warfarin until INR in therapeutic range +/- Vitamin K 2.5 mg PO
	Rapid reversal required	Hold warfarin and give Vitamin K 1-2 mg IV infusion or 2.5-5 mg PO
≥ 9	No bleeding	Hold warfarin until INR in therapeutic range and give Vitamin K 2.5-5 mg PO or 1-2 mg IV (may repeat q24h if necessary)
	Rapid reversal required	Hold warfarin and give Vitamin K 1-10 mg IV infusion and may repeat q6-24h if necessary
Any	Serious or life-threatening bleeding	Hold warfarin and give Vitamin K 10 mg IV infusion and supplement with FFP or PCC or recombinant fVIIa and repeat as necessary guided by INR

For more information, please visit <http://uwmcacc.org/>