UW Medicine

## *CONVERSION ("SWITCHING") FROM PARENTERAL TO ORAL ANTICOAGULATION FOR THE TREATMENT OF VTE*

| | **To warfarin** | **To dabigatran or edoxaban** | **To apixaban or rivaroxaban** |
|---|---|---|---|
| **Initial Parenteral Therapy** | Required | Required | **Not required** |
| **From Heparin or bivalirudin** | Start warfarin and heparin/bivalirudin concurrently.<br><br>Continue heparin/bivalirudin for a minimum of 5 days AND until INR > 2.0 | Start heparin/bivalirudin alone<br><br>After a minimum of 5 days of heparin, start dabigatran or edoxaban and stop heparin/bivalirudin | Stop heparin/bivalirudin *(initial parenteral therapy is not necessary for VTE treatment with apixaban or rivaroxaban)*.<br><br>Give first dose of apixaban or rivaroxaban |
| **From LMWH or Fondaparinux** | Start warfarin and LMWH/fondaparinux concurrently.<br><br>Continue LMWH/ fondaparinux for a minimum of 5 days AND until INR > 2.0 | Start LMWH/ fondaparinux alone<br><br>After a minimum of 5 days, stop LMWH/fondaparinux<br><br>Give first dose of dabigatran or edoxaban at the time the next dose of LMWH/ fondaparinux would have been given | Stop LMWH/ fondaparinux<br><br>Give first dose of apixaban or rivaroxaban at the time the next dose of LMWH/fondaparinux would have been given |