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 every ________days
☐ Baseline CBC and repeat every _________day(s) (*minimum suggested frequency is every 3 days*)
☒ Notify MD if unable to obtain blood sample for PT/INR check
☒ If on concurrent bivalirudin, refer to bivalirudin orders for warfarin monitoring with Chromogenic Factor X assay

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 2100)
___________mg	☐ Daily ☐ Today only

OR

Alternating Warfarin dose PO daily at 2100	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
____________mg	☐	☐	☐	☐	☐	☐	☐
____________mg	☐	☐	☐	☐	☐	☐	☐

OR

☐ **HOLD Warfarin x1 dose** [RN TO DOCUMENT "NOT GIVEN" ON eMAR TASK]
☐ **DISCONTINUE Warfarin and continue PT/INR monitoring** [NEW ORDER REQUIRED TO RESUME THERAPY]
☐ **DISCONTINUE Warfarin and discontinue PT/INR monitoring**

PHYSICIAN/ARNP/PA SIGNATURE	PRINT NAME	PAGER	NPI	DATE	TIME

PT.NO

NAME

DOB

UW Medicine Health System
Harborview Medical Center – UW Medical Center
Northwest Hospital & Medical Center – University of Washington Physicians
Seattle, Washington

INPATIENT WARFARIN ORDERS

U2924

WHITE - MEDICAL RECORD

UH2924 REV MAR 11

Refer to reverse for warfarin management resources

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

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

- 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://uwmacc.org/