NHS
Midlands and Lancashire
Commissioning Support Unit

What is the most appropriate anticoagulant for patients with non-valvular Atrial Fibrillation?

Prescribing tip for information

Warfarin is the most cost-effective and may be the preferred option for those people with AF. Where a Direct Oral Anticoagulant (DOAC) is considered to be the most appropriate, LMMG recommends that the DOAC with the lowest acquisition cost be prescribed first-line, unless there is a specific clinical reason not to do so.

Which anticoagulant to choose?

Warfarin is the most cost-effective and may be the preferred option for those people with AF:

- Who are currently well controlled on warfarin
- Who have never taken an anticoagulant (after discussing risks and benefits with the patient)
- Who are at risk of drug interactions with a DOAC
- Who have impaired renal function (eGFR <30 ml/min/1.73m^2)
- Who have no additional risk factors

DOACs may be the preferred option for people with AF:

- Who are not taking warfarin because of allergy or intolerance, or in circumstances where routine INR monitoring may be impractical (provided that monitoring of renal and liver function is still practicable)
- Who are currently taking warfarin but, despite evidence of good compliance with medication and monitoring, have poor anticoagulant control
- Who are at risk of drug interactions with warfarin

DOAC Choice - All DOACs are available in accordance with each specific NICE Technology Appraisal Guidance.

Where a DOAC is considered to be the most appropriate anticoagulant for patients with non–valvular AF, **LMMG recommends that the DOAC with the lowest acquisition cost be prescribed first-line, unless there is a specific clinical reason not to do so. Currently, this is EDOXABAN.**

It may be appropriate to consider an alternative DOAC as 1st line choice if:

- There is a high risk of ischaemic stroke and low bleeding risk
- Patient has suffered a previous stroke (secondary prevention)

The summary of product characteristics states that the recommended dose of edoxaban is 60 mg once daily.

The lower dose of 30 mg once daily is recommended in people with one or more of the following:

- moderate or severe renal impairment (creatinine clearance 15–50 ml/min);
- body weight of 60 kg or less;
- concomitant use of the P-glycoprotein inhibitors ciclosporin, dronedarone, erythromycin or ketoconazole.

This guidance does not override the individual responsibility of health professionals to make decisions in exercising their clinical judgement in the circumstances of the individual patient, in consultation with the patient and guardian or carer. For full prescribing information, please refer to the BNF and SPC.

To contact the Medicines Optimisation Team please phone 01772 214302