Do NOT switch to Edoxaban (from another DOAC) if...

- The patient has a metallic heart valve. They should not be prescribed any DOAC (they should be on warfarin).
- The patient is on a Direct-Acting Oral Anticoagulant (DOAC) for DVT or PE. Edoxaban is only the first line DOAC for non-valvular atrial fibrillation (NVAF) - see APC DOAC position statement.
- The patient is on concomitant antiplatelet therapy.
- The patient has a history of acute coronary syndrome. These patients may be discharged on a combination of rivaroxaban and one or more antiplatelets based on current evidence.
- The patient is on DOAC treatment post TAVI (transcatheter aortic valve implantation) or post coronary stenting.
- The patient has a history of gastrointestinal (GI) bleeding or ulcer or has an increased bleeding risk – use HASBLED or ORBIT score to assess risk.
- The patient has creatinine clearance (CrCl) <50ml/min. In this situation, clinicians usually select an alternative DOAC that is better supported by trial data at lower CrCl levels. CrCl must have been calculated using a recent body weight (within last 6 months). Do not use eGFR. Note that local specialists recommend avoiding DOACs in patients with CrCl <30ml/min due to increased risk of accumulation and bleeding.
- Creatinine clearance is more than 95ml/min, decreased efficacy of edoxaban with increasing CrCl.
- The patient, or their carer, is unlikely to understand the change.
- The patient is hypersensitive to the active substance or to any of the excipients.

If, after a thorough review considering the factors above, a switch is still being considered:

- Calculate renal function. Creatine clearance must have been calculated using a recent body weight (within last 6 months). Do not use eGFR for dosing.
- Check that the dose is correct according to indication, body weight, renal function – see APC Anticoagulants in AF Guideline.
- For patients with a weight >150kg, seek advice from specialist as to most appropriate DOAC/anticoagulant.
- Explain the switch at a face to face or telephone appointment. The switch must not be communicated by letter, text or email alone.
- Consider interactions with other medicines. Interactions with DOACs can be serious – see SPC and NUH DOAC interactions compilation.
- Caution if changing from a twice a day DOAC to edoxaban which is a once-a-day preparation.
- Ensure that the patient knows when to start edoxaban i.e. after they have finished their current DOAC supply.
- Patients should be informed that currently there is no licensed antidote for reversing anticoagulation from edoxaban. There is an antidote for reversing anticoagulation effect from apixaban and rivaroxaban for life-threatening or uncontrolled bleeding, only if the bleed is in the gastrointestinal tract and for intracranial haemorrhage, for eligible patients as part of a research study at NUH. There is a specific reversal agent for dabigatran.

This guidance has been produced by the CCG Medicines Optimisation Team in collaboration with colleagues in primary and secondary care with the aim of mitigating risk if switching to edoxaban is carried out in primary care.

The CCG is NOT advocating or endorsing switching from one DOAC to another where there is no clinical benefit to the patient.

Edoxaban is to be used first line for patients with NVAF unless there is a specific clinical reason not to do so – see APC DOAC position statement.