

GUIDANCE ON CONVERTING BETWEEN ANTICOAGULANTS

In general, switching between anticoagulants can expose patients to periods of increased thromboembolic and bleeding risks. All DOACs may affect INR measurements so interpret with caution. The interpretation and application of the information below remain the responsibility of the clinician. If in doubt, a senior colleague should be contacted or referral made to the appropriate specialist.

Starting Drug	Convert To	Recommendation
Vitamin K Antagonists (VKA) e.g. Warfarin	LMWH	For DVT/PE treatment and prevention of recurrence , stop warfarin and start treatment dose LMWH when INR < 2 For prevention of stroke and systemic embolism : review thrombotic risk on a case by case basis. Consider starting prophylactic or treatment dose LMWH when INR < 2
	Apixaban	Stop warfarin and start apixaban when INR < 2
	Rivaroxaban	For DVT/PE treatment and prevention of recurrence , stop warfarin and start rivaroxaban when INR ≤ 2.5 For prevention of stroke and systemic embolism , stop warfarin and start rivaroxaban when INR ≤ 3
	Edoxaban	Stop warfarin and start edoxaban when INR ≤ 2.5
	Dabigatran	Stop warfarin and start dabigatran when INR < 2
	Unfractionated heparin infusion	Stop warfarin and start infusion when INR < 2
Subcutaneous anticoagulants e.g. LMWH, fondaparinux and unfractionated heparin	Warfarin	Commence warfarin in combination with LMWH. Continue LMWH for at least 5 days, or until INR has been therapeutic on 2 consecutive days then stop LMWH
	Apixaban	Switching can be done at the next scheduled dose. Do not administer simultaneously
	Rivaroxaban	Stop LMWH and start rivaroxaban 0-2 hours before the time that the next scheduled administration of LMWH would be due. Do not administer simultaneously
	Edoxaban	Switching can be done at the next scheduled dose. Do not administer simultaneously
	Dabigatran	Stop LMWH and start dabigatran 0-2 hours prior to the time that the next dose of LMWH would be due. Do not administer simultaneously
	Unfractionated heparin infusion	Stop LMWH and start infusion at the time that the next dose of LMWH would be due
Apixaban	Warfarin	Continue apixaban for at least 2 days after starting warfarin. After 2 days of co-administration of apixaban with warfarin, an INR should be obtained prior to the next scheduled dose of apixaban. Co-administration of apixaban and warfarin should be continued until the INR is ≥ 2
	LMWH	Stop apixaban and start LMWH at the time the next dose of apixaban would be due. Do not administer simultaneously
	Rivaroxaban	Stop apixaban and start rivaroxaban at the time the next dose of apixaban would be due
	Edoxaban	Stop apixaban and start edoxaban at the time the next dose of apixaban would be due
	Dabigatran	Stop apixaban and start dabigatran at the time the next dose of apixaban would be due
	Unfractionated heparin infusion	Stop apixaban and start infusion at the time the next dose of apixaban would be due

Starting Drug	Convert To	Recommendation
Rivaroxaban	Warfarin	Give rivaroxaban and warfarin concurrently until INR is ≥ 2 . Measure INR prior to the next dose of rivaroxaban (no earlier than 24 hours after the previous dose)
	LMWH	Stop rivaroxaban and start LMWH at the time the next dose of rivaroxaban would be due. Do not administer simultaneously
	Apixaban	Stop rivaroxaban and start apixaban at the time the next dose of rivaroxaban would be due
	Edoxaban	Stop rivaroxaban and start edoxaban at the time the next dose of rivaroxaban would be due
	Dabigatran	Stop rivaroxaban and start dabigatran at the time the next dose of rivaroxaban would be due
	Unfractionated heparin infusion	Stop rivaroxaban and start infusion at the time that the next dose of rivaroxaban would be due
Edoxaban	Warfarin	<p>If on a 60mg dose, give edoxaban 30mg once daily with warfarin If on a 30mg dose, give edoxaban 15mg once daily with warfarin</p> <p>Patients should not take a loading dose of VKA in order to promptly achieve a stable INR between 2 and 3. It is recommended to take into account the maintenance dose of warfarin and if the patient was previously taking warfarin or to use valid INR driven warfarin treatment algorithm, in accordance with local practice.</p> <p>Once an INR ≥ 2 is achieved or after 14 days (whichever is sooner), edoxaban should be discontinued and warfarin continued to be titrated to achieve target INR.</p> <p>Check INR at least 3 times during the first 14 days of concomitant therapy just prior to taking the daily dose of edoxaban (to minimise the influence of edoxaban on INR measurements).</p>
	LMWH	Stop edoxaban and start LMWH at the time the next dose of edoxaban would be due. Do not administer simultaneously
	Rivaroxaban	Stop edoxaban and start rivaroxaban at the time the next dose of edoxaban would be due
	Apixaban	Stop edoxaban and start apixaban at the time the next dose of edoxaban would be due
	Dabigatran	Stop edoxaban and start dabigatran at the time the next dose of edoxaban would be due
	Unfractionated heparin infusion	Stop edoxaban and start infusion at the time the next dose of edoxaban would be due
Dabigatran	Warfarin	<p>Starting time should be adjusted based on CrCL as follows: CrCL ≥ 50 mL/min, start warfarin 3 days before discontinuing dabigatran CrCL 30 - 49 mL/min, start warfarin 2 days before discontinuing dabigatran</p> <p>Note: Dabigatran can impact the INR. INR values should be interpreted with caution until dabigatran has been stopped for at least 2 days.</p>
	LMWH	Stop dabigatran and start LMWH 12-24 hours (<i>see dose specific SPC</i>) after the last dose of dabigatran
	Rivaroxaban	Stop dabigatran and start rivaroxaban at the time the next dose of dabigatran would be due
	Apixaban	Stop dabigatran and start apixaban at the time the next dose of dabigatran would be due
	Edoxaban	Stop dabigatran and start edoxaban at the time the next dose of dabigatran would be due
	Unfractionated heparin infusion	Stop dabigatran and start infusion 12-24 hours (<i>see dose specific SPC</i>) after the last dose of dabigatran

Starting Drug	Convert To	Recommendation
Unfractionated Heparin Infusion (UFH)	Warfarin	Start warfarin and stop infusion once INR is in therapeutic range for 2 consecutive days
	LMWH	Stop heparin infusion and start LMWH at the time of discontinuation of the infusion
	Apixaban	Start apixaban at the time of discontinuation of the infusion
	Rivaroxaban	Start rivaroxaban at the time of discontinuation of the infusion
	Edoxaban	Stop heparin infusion and start edoxaban 4 hours later
	Dabigatran	Start dabigatran at the time of discontinuation of the infusion

References

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