WARFARIN DOSING

INITIATION OF THERAPY

- Obtain baseline complete blood count (CBC)
- Determine if drug interactions with warfarin are present.
- Initial dosage is usually 2.5-5 mg. The elderly usually require doses of less than 5 mg/day to maintain a therapeutic INR due to increased pharmacodynamic activity. 2.5 mg/day is recommended.
- If enoxaparin is being administered concurrently with warfarin after event/surgery (bridge therapy), discontinue enoxaparin after the INR has been in the therapeutic range (2-3) for at least two measurements taken ≥ 24 hours apart and at least 5 days of combined enoxaparin/warfarin therapy.
- For ambulatory elderly patients in chronic atrial fibrillation, who are not undergoing elective cardioversion, some clinicians may initiate therapy with a dose of 2.5 mg daily, obtain INR monitoring in 3 to 4 days, and adjust therapy accordingly.

MAINTENANCE THERAPY

Patient's INR[+]					
<1.5	1.5-1.9	2.0-3.0	3.1-3.9	4.0-4.9	≥ 5.0
Dosage Change					
Increase weekly dose by10% Consider extra dose	Increase weekly dose by 5-10%*	No change	Hold 1-2 doses Decrease weekly dose by 5 - 10%**	Hold 1-2 doses Decrease weekly dose by 10%	Refer to Table below
Repeat INR					
3-5 days until Target INR is reached	3-5 days until Target INR is reached	See Follow-up Algorithm	2 days until Target INR is reached	2 days until Target INR is reached	Refer to Table below

[+]Assumes maintenance therapy after achievement of therapeutic INR.
*If INR 1.8-1.9, consider no change with repeat INR in 3-4 days.
**If INR 3.1-3.3, consider no change with repeat INR in 2-4 days.

MANAGING HIGH INR VALUES

INR 5.0-8.9 No Significant Bleeding	Withhold doses, monitor INR every day; resume warfarin therapy at lower dose when INR approaches target range. Patients at increased risk of bleeding: omit the next dose of warfarin and give vitamin K_1 1 – 2.5 mg orally. For more rapid reversal give vitamin K 2 – 4 mg. Vitamin K_1 1 – 2 mg may be given 24 hours later if INR remains high.
INR > 9.0 No Significant Bleeding	Withhold warfarin; give Vitamin K_1 (2.5-5 mg orally); closely monitor (at least daily) INR and symptoms/signs of bleeding; If not substantially reduced in 24-48 hrs., may require additional Vitamin K_1. Resume warfarin therapy at a lower dose when the INR reaches target range.
Significant Bleeding	Transfer to an acute care setting. Discontinue warfarin; administer Vitamin K_1 (10 mg slow IV infusion) supplemented with fresh plasma or prothrombin complex concentrate, depending on urgency; Vitamin K_1 injections can be repeated every 12 hours.

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