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Prescribing Matters

Milton Keynes Prescribing Advisory Group

Circulation to all GP practices FAO all Clinicians, Community Pharmacists, Hospital and CCG staff

The Newer Oral Anticoagulants (NOACs) - Apixaban

For Prevention Of Stroke And Systemic Embolism In Atrial Fibrillation

NICE TA275 BNF Category: 2.8.2

In AF where warfarin cannot be given Apixaban is the MKPAG recommended NOAC

How can this bulletin help help you?

Our aim is to support the safe and effective use of the newer oral anticoagulant drugs (NOACs) across the NHS in Milton Keynes.

The focus of AF management should be to undertake stroke risk assessment and use an anticoagulant where appropriate.

The MHRA has issued advice about the safe use of the newer oral anticoagulants (dabigatran, rivaroxaban and apixiban). October 2013

1. *Unlike vitamin K antagonists (warfarin, phenindione) there is no need for routine monitoring of anticoagulant activity when administering these medicines.*
2. *However, **clinical trials and post-marketing experience have shown that major bleeding events, including events leading to death, are not confined to vitamin K antagonists/LMWH but are also significant risks for the newer oral anticoagulants.***
3. *Furthermore, post-marketing surveillance reports indicate that not all prescribers are sufficiently aware of the product information in terms of managing bleeding risks.*
4. ***It is important to pay attention to the recommended posology and the warnings and precautions for use to minimise the risk of bleeding. This includes a careful benefit-risk assessment in patients with lesions, conditions, procedures and/or treatments (such as NSAIDs& antiplatelets), which increase the risk of major bleeding.***
5. ***Clinical surveillance for signs and symptoms of bleeding is recommended throughout the treatment period,***
6. ***Attention should also be paid to renal function including on-treatment deterioration.***

Anticoagulation in AF

Warfarin remains our first-line oral anticoagulant for patients in atrial fibrillation.

Warfarin should be the preferred option in patients with:

- eGFR <30 (Patients with a baseline eGFR of 30-40 are at risk of progressive/acute renal dysfunction and potential risks of bleeding with dabigatran or rivaroxaban should be weighed on an individual basis.
- a history of significant peptic ulceration
- Significant ischaemic heart disease in absence of other determining considerations

MKPAG RECOMMENDED PLACE IN THERAPY FOR NOACs

On the balance of risks and benefits, we suggest the use of Warfarin is considered for people with high-risk atrial fibrillation score.

The Newer Oral AntiCoagulants (NOACs) are only recommended by NICE to be used as an option, as an alternative to warfarin.

Following extensive discussion with clinicians in both primary and secondary care, **where warfarin cannot be used Apixaban is our locally recommended NOAC for prevention of stroke and systemic embolism in atrial fibrillation.**

NICE has advised that it is the most cost-effective NOAC, due to its lower bleeding risk

Apixaban is recommended by MKPAG as an option where warfarin is either contraindicated or where the patient has a documented hypersensitivity to or intolerance of coumarin anticoagulants severe enough to cause treatment withdrawal.

In situations where repeated international normalized ratio (INR) testing / monitoring may be impractical, the use of Apixaban may be considered.

Contraindications:

1. Lesion or condition, if considered to be a significant risk for major bleeding.
2. Concomitant treatment with any other anticoagulants
3. Hepatic disease
4. Pregnancy and breast feeding

(See SPC for full details)

Who should initiate NOAC therapy?

MKPAG recommends that Apixaban may be initiated by GPs or a secondary care consultant cardiologist or stroke physician as appropriate.

** Hospital initiation of a NOAC can be passed to the GP practice with advice on responsibility for the on-going monitoring e.g. any required plan for specialist follow-up, and should make clear the expected arrangement for future eGFR monitoring and for regular assessment of bleeding risks/events.

** Initiation can be in primary care, ensuring appropriate arrangements are in place to monitor patients and check compliance.

How safe are the NOACs?

Long term safety and tolerability of these new agents is not yet known.

There is no specific antidote available for any of the three NOACs.

There are currently no tests to assess the level of anticoagulation (under or over) being achieved.

No INR testing can be done, or is specified, for any NOAC. Other factors for considerations are:

The patient's current INR, other interacting medicines, renal function, bleeding risks, especially GI bleeding risk.

The effect of non-compliance might be more significant because of NOACs' short half-lives compared to warfarin, and the absence of tests to monitor coagulation levels.

Comparative cost of 1 year treatment

Drug	Cost for 1 patient	Cost for 100 patients
Warfarin 5mg OD + monitoring	£12 +£112 pa	£12,400
Apixaban 5mg BD	£790	**£79,070**

NOACs are all still black triangle ▼drugs.

Whilst they have a shorter half-life than warfarin, they have no simple antidotes.

** Warfarin has been in use for over 60 years, its effects are measurable and can be rapidly reversed in event of major bleeding.

** Dosage regimes and further information can be found in the BNF or SPC.

The decision about whether to start a NOAC should be made after an informed discussion between the clinician and the patient about the risks and benefit of NOACs compared to warfarin

Glossary of abbreviations

NICE TAs: National Institute for Health and Care Excellence Technology Appraisals

MHRA: Medicines and Healthcare Products Regulatory Agency

SPC: Summary of Product Characteristics

For further information and references, please contact Dupe Fagbenro, MK Prescribing Advisory Group, Pharmacy Department, Milton Keynes Hospital NHS Foundation Trust.

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