Apixaban Indications , Dosage and Administration

Lepixa

Indications	Recommended Dose
Prevent stroke and systemic embolism in NVAF patients	5 mg twice daily in most patients **Dose adjustment for NVAF patients:** 2.5 mg twice daily is recommended for patients with at least 2 of the following characteristics: A Age≥80 years B Body weight≤60 kg C Creatinine≥1.5 mg/dl
Treatment of DVT/PE	**Frist 7 days** 10 mg twice daily (Two 5mg tablets) **After 7 days** 5 mg twice daily (One 5mg tablet)
Reduction in the risk of recurrent DVT and PE following initial therapy	2.5 mg twice daily after at least 6 months of treatment for DVT or PE
Prophylaxis of DVT following hip or knee replacement surgery	2.5 mg twice daily Knee: For 12 days Hip: For 35 days

Use in Specific Populations

Nursing Mothers Discontinue drug or discontinue nursing.

Pregnancy Not recommended.

Pediatric Use Safety and effectiveness in pediatric patients have not been established.

Geriatric Use Of the total subjects in clinical studies of Apixaban, >69% were 65 and older, and >31% were 75 and older. The effects of Apixaban on the risk of stroke and major bleeding compared to Warfarin were maintained in geriatric subjects.

Dosing in Patients with Renal Impairment

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Indications	Recommended Dose
Nonvalvular atrial fibrillation (to prevent stroke and systemic embolism)	• **Serum creatinine <1.5 mg/dL** No dosage adjustment necessary unless ≥80 years of age and body weight ≤60 kg, then reduce dose to 2.5 mg twice daily • **Serum creatinine ≥1.5 mg/dL and either ≥80 years of age or body weight ≤60 kg** 2.5 mg twice daily • **Severe or ESRD not requiring hemodialysis** 2.5 mg twice daily for CrCl 15 to 29 ml/min • **ESRD requiring hemodialysis** CrCl< 15 ml/min: 5 mg twice daily
Treatment and prevention of DVT/PE	**No dose adjustment needed.**

Dosing in Patients with Hepatic Impairment

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Mild impairment (Child-Pugh class A)	No dosage adjustment required.
Moderate impairment (Child-Pugh class B)	There are no dosage adjustments provided in manufacturer's labeling; use with caution .
Severe impairment (Child-Pugh class C)	Use is not recommended.

Apixaban Drug Interactions

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Strong dual CYP3A4 and P-glycoprotein inhibitors (eg, ketoconazole, Itraconazole, Ritonavir)

Increase blood level of Apixaban

Clarithromycin

Although Clarithromycin is a combined P-gp and strong CYP3A4 inhibitor, pharmacokinetic data suggest that no dose adjustment is necessary with concomitant administration with Apixaban.

•Recommended Apixaban doses >2.5 mg twice daily: **Reduce Apixaban dose by 50%.**

•Recommended Apixaban dose of 2.5 mg twice daily: **Avoid concomitant use.**

Strong dual CYP3A4 and P-glycoprotein inducers (eg, Rifampin, Carbamazepine, Phenytoin, St John's wort)

Reduce blood level of Apixaban

Avoid concomitant use.

Apixaban contraindications

Active pathological bleeding.

Severe hypersensitivity reaction to Apixaban (e.g., anaphylactic reactions).

Missed Dose

•The patients can take the missed dose as soon as they think about it.
•If it is close to the time for the next dose, the patients have to skip the missed dose and go back to their normal time.
•It doesn't need to take 2 doses at the same time or extra doses.

Lepixa
Apixaban F.C. tablets 2.5, 5 mg

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Transitioning from Another Anticoagulant to Apixaban

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Transitioning from low-molecular-weight Heparin or Fondaparinux to Apixaban	**General transition:** Initiate Apixaban at the time of the next scheduled dose of the parenteral anticoagulant. **Venous thromboembolism initial treatment transition (alternate recommendation):** For acute VTE, some experts start Apixaban ***within 6 to 12 hours after the last dose of a twice daily LMWH regimen or within 12 to 24 hours after a once daily regimen.***
Transitioning from unfractionated Heparin continuous infusion to Apixaban	**Start Apixaban when the parenteral anticoagulant infusion is stopped.**
Transitioning from Warfarin to Apixaban	**Discontinue Warfarin and initiate Apixaban following the instructions:** • If the INR is less than 2, start treatment with Apixaban. • If the INR is between 2 and 2.5, start treatment with Apixaban the next day. • If the INR is greater than 2.5, wait until the patient`s INR has dropped to less than 2 before starting treatment with Apixaban
Transitioning from Rivaroxaban to Apixaban	Discontinue Rivaroxaban and initiate Apixaban at the time of the next scheduled dose of Rivaroxaban.

References

▶ https://www.accessdata.fda.gov/drugsatfda_docs/label/2012/202155s000lbl.pdf
▶ Drug Information: Apixaban. In: UpToDate [database on internet]. Waltham (MA): UpToDate, Inc.; 2021
▶ Mbroh J, Poli S. 2021 European Heart Rhythm Association Practical Guide on the use of non-vitamin K antagonist oral anticoagulants in patients with atrial fibrillation: comment. EP Europace. 2021 Sep 4.

Timing of Last Non-Vitamin K Antagonist Oral Anticoagulant Intake before Start of an Elective Intervention According to Renal Function

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No perioperative bridging with LMWH / UFH

Minor Risk Procedures : perform procedure at NOAC trough level (i.e., 12 h / 24 h after last intake)
Resume same day or latest next day

	Low Risk	High Risk
CrCl>80 ml/min CrCl 50-79 ml/min CrCl 30-49 ml/min	>24 h	> 48 h
CrCl 15-29 ml/min	> 36h	
CrCl < 15 ml/min	No official indication for use	

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