ICHECK'D: Mnemonic approach to DOAC safety*

ICHECK'D	Apixaban (Eliquis®)	Rivaroxaban (Xarelto®)	Dabigatran (Pradaxa®)	Edoxaban (Savaysa®)
Indication	**NVAF, VTE, VTE prophylaxis (knee and hip)**	**NVAF, VTE, VTE prophylaxis (knee and hip), CAD/PAD, VTE prophy for acutely ill**	**NVAF, VTE, VTE prophylaxis (hip only)**	**NVAF, VTE**
Concomitant meds	**All pts:** If 5 mg or 10 mg twice daily, reduce 50% when given with: conivaptan, indinavir/ritonavir, itraconazole, ketoconazole, lopinavir/ritonavir, ritonavir, voriconazole If 2.5 mg twice daily, avoid giving with: conivaptan, indinavir/ritonavir, itraconazole, ketoconazole, lopinavir/ritonavir, ritonavir, voriconazole Avoid giving with: carbamazepine, phenytoin, rifampin, St. John's wort, enzalutamide, apalutamide	**All pts:** Avoid giving with: conivaptan, indinavir/ritonavir, itraconazole, ketoconazole, lopinavir/ritonavir, ritonavir, voriconazole, carbamazepine, phenytoin, rifampin, St. John's wort, enzalutamide, apalutamide Avoid with CrCl 15 to < 80 mL/min and receiving: diltiazem, dronedarone, erythromycin, verapamil	**All pts:** Avoid giving with carbamazepine, phenytoin, rifampin, St. John's wort, tipranavir/ritonavir **NVAF:** If CrCl 30-50 mL/min, and concomitant use of P-gp inhibitors* or dronedarone or systemic ketoconazole, reduce dose to 75 mg twice daily. Avoid if CrCl < 30 mL/min with concomitant use of P-gp inhibitors* **VTE and VTE prophy:** Avoid if CrCl < 50 mL/min with concomitant use of P-gp inhibitors* *P-gp inhibitors: Amiodarone, azithromycin, captopril, carvedilol, clarithromycin, conivaptan, cyclosporine, diltiazem, dronedarone, erythromycin, felodipine, itraconazole, ketoconazole, lopinavir, ritonavir, quercetin, quinidine, ranolazine, verapamil	**All pts:** Avoid giving with rifampin citalopram, escitalopram, fluoxetine, paroxetine, sertraline, vilazodone, desvenlafaxine, duloxetine, venlafaxine, venlafaxine XR, milnacipran, levomilnacipran **VTE:** 30 mg daily if taking **verapamil, quinidine, azithromycin, clarithromycin erythromycin, itraconazole (oral), ketoconazole (oral)

	Apixaban (Eliquis)	Rivaroxaban (Xarelto)	Dabigatran (Pradaxa)	Edoxaban (Savaysa)
History	Contraindicated if mechanical heart valve, moderate to severe mitral stenosis, hepatic impairment (Child-Pugh class B or higher), pregnant or nursing			
Education	Review risk for bleeding, S/S of bleeding, procedures when dose may need to be held			
Compliance	Reinforce missing/skipping doses may increase the risk for clotting			
Kidney function	**NVAF:** serum creatinine value	**NVAF:** CrCl via Cockcroft-Gault formula (actual wt)	**NVAF & VTE:** CrCl via Cock-croft-Gault form. (actual wt)	**NVAF:** CrCl via Cockcroft-Gault formula (actual wt)
Dose	**NVAF:** 5 mg BID. Reduce to 2.5 mg BID if **at least two** of the following: age ≥ 80 years, body weight ≤ 60 kg or serum creatinine ≥ 1.5 mg/dL **VTE:** 10 mg BID x 7 days and then decrease to 5 mg BID **Secondary VTE Prevention**: may decrease to 2.5 mg BID after at least 6 months of treatment **VTE prophy**: 2.5 mg BID for 12 days (knee) or 35 days (hip)	**NVAF:** 20 mg daily with evening meal. Reduce to 15 mg daily with evening meal if CrCl ≤ 50 mL/min or if on dialysis **VTE:** 15 mg BID with food x 21 days and then decrease to 20 mg daily with food. After 6 months of treatment may de-crease to 10 mg daily. Avoid if CrCl < 15 mL/min or on dialysis **VTE prophy:** 10 mg daily for 12 days (knee) or 35 days (hip). Avoid if CrCl < 15 L/min or on dialysis **CAD/PAD:** 2.5 mg BID in combi-nation with daily ASA (75-100 mg) **VTE prophy for acutely ill#:** 10 mg daily for 31-39 days Avoid if CrCl < 15 L/min or on dialysis	**NVAF:** 150 mg BID. Reduce dose to 75 mg BID if CrCl 15-30 mL/min. Avoid if CrCl < 15 mL/ min or on dialysis **VTE:** 150 mg BID after 5-10 days of parenteral anticoagulant. Avoid if CrCl ≤ 30 mL/min or on dialysis **VTE prophy (hip only):** Initial = 110 mg x 1 then 220 mg daily for 28-35 days. Avoid if sCrCl ≤ 30 mL/min or on dialysis	**NVAF:** 60 mg daily if CrCl ≤ 95 mL/min. Reduce dose to 30 mg daily if CrCl is 15-50 mL/min. Avoid if CrCl > 95 mL/min or < 15 mL/min **VTE:** 60 mg daily after 5-10 days of parenteral anticoagu-lant. Reduce dose to 30 mg daily if CrCl is 15-50 mL/min **or** body weight ≤ 60 kg **or** using any P-gp inhibitors listed above**. Not recommended if CrCl < 15 mL/min

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#Prophylaxis of VTE in acutely ill medical patients at risk for VTE complications not at high risk of bleedingAbbreviations: CrCl= creatinine clearance; P-gp= p-glycoprotein; NVAF= nonvalvular atrial fibrillation; VTE= venous thromboembolism.; pts= patients; wt= weight For questions or permissions, please email info@maqi2.org. Version 1.4, 12/3/19. For additional resources, visit www.anticoagulationtoolkit.org