

DABIGATRAN

Information for transitioning patients to dabigatran (Pradaxa)



Since the introduction of dabigatran (Pradaxa) on the Pharmaceutical Schedule on 1 July 2011, there have been some reports of bleeding among patients being transitioned onto dabigatran. Bleeding is a recognised potential adverse effect of dabigatran and these reports are being evaluated to see if there is any consistent pattern.

It is important to remember that dabigatran is indicated only for:

- Prevention of stroke, systemic embolism and reduction of vascular mortality in atrial fibrillation (AF)
- Venous thromboembolism (VTE) prophylaxis following major orthopaedic surgery

Before prescribing dabigatran you should ensure that you are fully conversant with the relevant literature including:

- The medicine datasheet available from the Medsafe website: www.medsafe.govt.nz
- Supplementary information available via the PHARMAC and bpac^{nz} websites: www.pharmac.govt.nz and www.bpac.org.nz

When initiating dabigatran ensure that:

- For those on warfarin, stop warfarin and make sure that the patient's INR is < 2.0 before starting dabigatran
- Consider each patient's renal function and creatinine clearance. Do not prescribe dabigatran if the patient's creatinine clearance is < 30mL/min
- For treatment of atrial fibrillation in patients aged > 80 years, prescribe 220 mg to be taken as 110 mg twice daily
- Take particular care when prescribing dabigatran for patients in residential care facilities. Make sure to check renal function and INR levels in each patient before prescribing dabigatran.

If a patient is well controlled on warfarin, there is no particular reason to change to dabigatran at least in the short term.

Further information about dabigatran will be available in a future edition of the Best Practice Journal.