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Is Dabigatran (Pradaxa®) an Option for Your Patient?

(Note: A generic product is on the market. Availability on provincial formularies varies by province)

Indications[1]

- ❑ Atrial Fibrillation to prevent stroke & systemic embolism
- ❑ Acute VTE treatment & prevention of recurrent VTE [for deep vein thrombosis (DVT) and pulmonary embolism (PE)]
  - Heparin Induced Thrombocytopenia (not an official indication) – guidelines recommend use in select patients (most data is with rivaroxaban)[2]
- ❑ Prevention of venous thromboembolic events (VTE) in elective total hip or knee replacement surgery (THR, TKR)

Requirements[1] **-** NOTE: Dabigatran accumulates in renal dysfunction

- ❑ Stable creatinine clearance (CrCl) greater than 30 mL/min

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Contraindications[1,3]

- ❑ Mechanical heart valves or moderate-severe mitral stenosis (rheumatic and non-rheumatic) [1,3,4]
- ❑ Dabigatran, like other anticoagulants, is contraindicated in patients at high risk for bleeding
- ❑ Pregnant/Breastfeeding: Safety & dosing has not been studied. Use is NOT recommended
- ❑ Drug Interactions: Significant drug interactions involving P-glycoprotein - See below

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Potential Limitations[1]

- ❑ Not recommended in hemodynamically unstable acute PE or those requiring thrombectomy or thrombolysis
- ❑ Not recommended in antiphospholipid syndrome with a history of thrombosis (especially triple positive)
- ❑ Drug Interactions: AVOID rifampin, select azole antifungals & anticonvulsants, protease inhibitors (e.g. ritonavir), glecaprevir/pibrentasvir, ticagrelor, St. John's Wort, and other strong P-gp inducers and inhibitors as there is minimal knowledge of clinical outcomes
- ❑ Rapid decline in anticoagulant effect after a missed dose; adherence is critical
- ❑ Limited data does not support use if over 120 kg or BMI > 40[5]; limited data in under 50 kg
- ❑ Less than 18 years of age: not indicated for use in Canada
- ❑ In acute treatment of VTE: Must be preceded by 5-10 days of parenteral anticoagulant
- ❑ Dyspepsia
- ❑ AF: dabigatran 150mg BID showed higher GI bleed rate than warfarin, but no difference in overall bleeding events[6]
- ❑ Product monograph indicates must remain in original blister package or manufacturer's bottle.[1] Recent data indicates stability outside of the manufacturer's packaging, but the clinical implications of this storage are not yet known[7]

Dosing Recommendations[1]

Indication	CrCl 50 mL/min or greater	CrCl 30–49 mL/min	CrCl less than 30mL/min
Stroke Prevention in Atrial Fibrillation	• 150 mg BID • 110 mg BID if ≥ 80 years of age. Also consider if >75 years old and ONE or more risk factor for bleeding (e.g. CrCl 30 - 49 mL/min, on antiplatelets, or interacting medication, etc.)		Contraindicated
Acute DVT/PE Treatment	Parenteral Anticoagulant x 5-10 days, then dabigatran as per AF dosing#		
Hip & Knee Replacement	110 mg initial dose*, then 220 mg once daily x 10 (TKR) to 28-35 days (THR)	75 mg initial dose*, then 150 mg once daily x 10 (TKR) to 28-35 days (THR)	

110 mg BID dose not studied for VTE treatment, but is suggested as per AF indication above[1]

*Initiate 1-4 h after surgery once hemostasis secured. If not started day of surgery, initiate with the daily maintenance dose

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Monitoring Patients on Dabigatran

- CrCl should be determined at baseline and at least annually. Monitor more frequently if older than 75y, with renal dysfunction (CrCl <60 mL/min), or when a decline in renal function suspected
- Monitor for symptoms and signs of bleeding
- No routine coagulation testing required. NOTE: INR is not useful for monitoring. Do not target INR 2 to 3
- If excess anticoagulation suspected, or to determine presence of dabigatran, an aPTT or more specifically a Thrombin Time (TT) may be considered. Normal values indicate little to no dabigatran present; however, a normal aPTT does not exclude presence of residual dabigatran. Specialized testing (e.g. dilute TT, Hemoclot™) may not be widely available, and should only occur in consultation with an expert in anticoagulation

Switching Between Agents[1]

From warfarin to dabigatran:

- Discontinue warfarin and start dabigatran once INR is less than 2

From non-warfarin anticoagulant (oral or parenteral - e.g. LMWH, rivaroxaban, apixaban, edoxaban) **to dabigatran:**

- Start dabigatran 0 - 2 hours before the next scheduled dose of non-warfarin anticoagulant was to be administered
- For agents administered by continuous infusion, stop the infusion and start dabigatran at the same time

From dabigatran to warfarin:

- Start warfarin and only discontinue dabigatran once INR is 2 or greater

From dabigatran to non-warfarin anticoagulants (oral or parenteral): (e.g. LMWH, rivaroxaban, apixaban, edoxaban)

- CrCl 30 mL/min or greater: Give 1st dose of non-warfarin anticoagulant 12 hours after the last dose of dabigatran
- CrCl Less than 30 mL/min: Give 1st dose of non-warfarin anticoagulant 24 hours after the last dose of dabigatran[8]

Management of Bleeding Episodes with Dabigatran

- In the event of major hemorrhagic complications, discontinue dabigatran and refer patient for urgent assessment and locally developed management strategies
- Idarucizumab (Praxbind™) is a rapid acting, target specific antidote, administered as an IV infusion / IV bolus for life threatening/uncontrolled bleeding or for emergency surgery/urgent procedures[9,10]
- PCC/activated PCC may reverse anticoagulant effect[11], but the effect of these agents on bleeding outcomes is limited
- Vitamin K, protamine, tranexamic acid, plasma and/or andexanet alfa will not reverse drug effects

Anticoagulation around Invasive Procedures[12] (e.g. surgery, elective day procedures, major dental procedures)

- As with warfarin, very low risk bleed procedures (such as dental extraction) do not require withholding dabigatran
- Management plans should be made in consultation with the provider performing the procedure
- Renal function significantly impacts clearance of dabigatran. If the recommendations below cannot be met, consultation with an expert in anticoagulation management is encouraged
- Due to the onset/offset time of dabigatran, peri-procedural use of LMWH is not required

Pre-Procedure- If required, stop dabigatran before procedure as follows:

Renal function# (CrCl mL/min)	Last intake of drug prior to procedure	
	Low Bleeding Risk	High Bleeding Risk*
80 or more	at least 24 hours	at least 48 hours
50 - 79	at least 36 hours	at least 72 hours
30 - 49	at least 48 hours	at least 96 hours

If CrCl less than 30 mL/min, dabigatran is contraindicated: Hold drug at least 5 days[1]

* Make a careful decision (i.e. hold longer) for patients undergoing major surgery, spinal puncture, or other regional anaesthesia in whom complete hemostasis is required. Consult specialist in these high risk patients/procedures

For an interactive perioperative management algorithm, see Thrombosis Canada website:
https://thrombosiscanada.ca/hcp/practice/clinical_tools?calc=perioperativeAnticoagulantAlgorithm

Post Procedure: Resumption should not be initiated until adequate hemostasis has been achieved and clinical situation allows (usually 1-3 days). NOTE: Full therapeutic effect occurs approximately 2 hours after ingestion

References: **1.** Product Monograph Pradaxa® Product Monograph (Boehringer Ingelheim Canada), March 23, 2020. **2.** Heparin-Induced Thrombocytopenia (HIT). https://thrombosiscanada.ca/clinical_guides/pdfs/HEPARININDUCEDTHROMBOCYTOPENIA_38.pdf Accessed January 7, 2025. **3.** Andrade JG et al. Can J Cardiol 2020; 36: 1847-1948. **4.** Eikelboom JW, et al. N Engl J Med 2013;369(13):1206-14. **5.** Direct Oral Anticoagulants in Obese Patients. https://thrombosiscanada.ca/clinical_guides/pdfs/92_35.pdf Accessed January 7, 2025. **6.** Connolly SJ, et al. N Engl J Med 2009;361(12):1139-51. **7.** Wang EH, et al. Can J Hosp Pharm 2015;68(1): 16-21. **8.** Pradaxa® Full Prescribing Information (Boehringer Ingelheim Pharmaceuticals, Inc. USA), June 2021. **9.** Pollack CV, et al. N Engl J Med 2017;377:431-441. **10.** Praxbind™. Product Monograph Including Patient Medication Information. (Boehringer Ingelheim, Burlington, Ontario). April 18, 2019. **11.** Eerenberg ES, et al. Circulation 2011;124(14):1573-9. **12.** Steffel J, et al. Europace 2021; 23:1612-1676.