

RWJUH COVID 19 Inpatient Anticoagulation Recommendations

Screening Questions:

- History of HIT/Heparin allergy?
- Personal or family history of bleeding?
- ANY bleeding in last 3 months/recent surgery/peptic ulcer/acute unexplained drop in Hgb \geq 2g from baseline
- ❖ Consider Hematology Consultation

Labs on AC Initiation AND Dose Escalation:

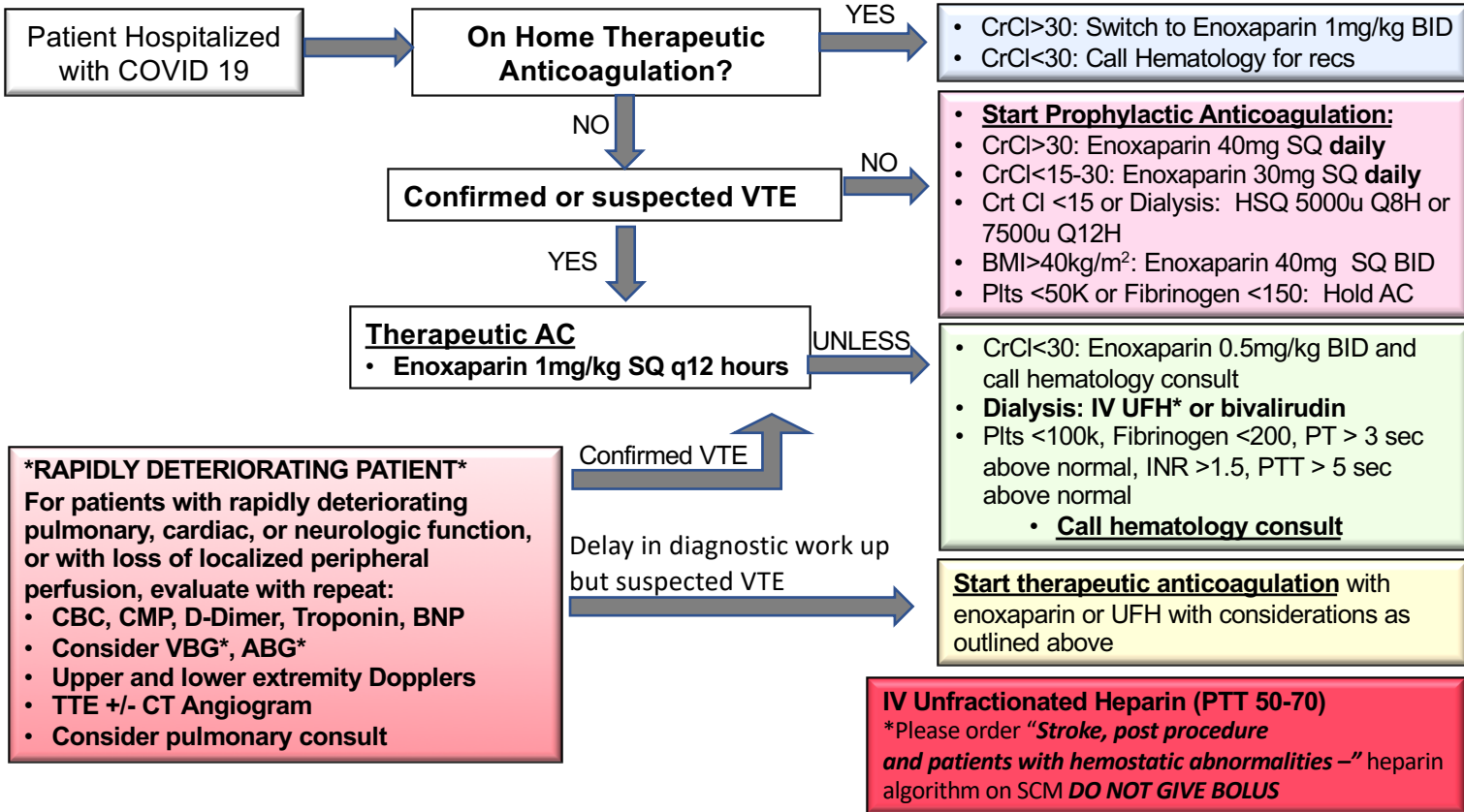
- Complete blood count (CBC)
- Complete metabolic panel (CMP)
- PT/PTT/INR
- Fibrinogen
- D-Dimer

Consider Hematology Consult:

- ECMO, LVAD, CVVHD
- Worsening AKI
- Active bleeding

Special Considerations:

- ❖ For patient on antiplatelets, please evaluate if its use is indicated.
- ❖ SCDs if patient can not be on AC
- ❖ Start PPI for AC/anti-platelets/steroid use h/o PUD, GERD, chronic NSAID hx
- ❖ GI consultation before anticoagulation if active PUD, hx of GIB w/o proven healing, decomp. cirrhosis



RAPIDLY DETERIORATING PATIENT
For patients with rapidly deteriorating pulmonary, cardiac, or neurologic function, or with loss of localized peripheral perfusion, evaluate with repeat:

- CBC, CMP, D-Dimer, Troponin, BNP
- Consider VBG*, ABG*
- Upper and lower extremity Dopplers
- TTE +/- CT Angiogram
- Consider pulmonary consult

- CrCl>30: Switch to Enoxaparin 1mg/kg BID
- CrCl<30: Call Hematology for recs

Start Prophylactic Anticoagulation:

- CrCl>30: Enoxaparin 40mg SQ daily
- CrCl<15-30: Enoxaparin 30mg SQ daily
- CrCl <15 or Dialysis: HSQ 5000u Q8H or 7500u Q12H
- BMI>40kg/m²: Enoxaparin 40mg SQ BID
- Plts <50K or Fibrinogen <150: Hold AC

- CrCl<30: Enoxaparin 0.5mg/kg BID and call hematology consult
- Dialysis: IV UFH* or bivalirudin
- Plts <100k, Fibrinogen <200, PT > 3 sec above normal, INR >1.5, PTT > 5 sec above normal
- Call hematology consult

Start therapeutic anticoagulation with enoxaparin or UFH with considerations as outlined above

IV Unfractionated Heparin (PTT 50-70)
*Please order "Stroke, post procedure and patients with hemostatic abnormalities --" heparin algorithm on SCM **DO NOT GIVE BOLUS**

❖ **Discharge Planning:**

For patients with no known VTE:

- Do not recommend anticoagulation on discharge

For patients on therapeutic anticoagulation and confirmed VTE:

- Continue therapeutic anticoagulation (Inpatient Enoxaparin dose, Eliquis 5mg BID, Xarelto 20mg daily) for at least 3 months and Hematology follow up

DOACS should be avoided on discharge if Child-Pugh Class B or C