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Edoxaban

Put up your hand if you want another anticoagulant to deal with. Edoxaban (Lixiana®) has joined the ODB parade to further complicate our lives. Is this a valuable addition or just another "me-too" drug? I'll make a few comments and you can decide for yourselves.

Edoxaban works like apixaban and rivaroxaban (Xarelto®). It blocks formation of thrombin in the clotting cascade. Since thrombin converts fibrinogen to fibrin (the protein strands forming the clot), coagulation is inhibited. Pradaxa® blocks formation of fibrin directly, so it is a bit different.

The ENGAGE trial showed high-dose edoxaban (60 mg daily) was no worse than warfarin in preventing clots in those with atrial fibrillation, and that it caused less major bleeding and CV death. The lower dose (30mg daily) did not perform as well as 60 mg in preventing stroke (LU 554). It could be argued that these results are similar to the Rocket AF trial (Xarelto®), RELY (Pradaxa®) and ARISTOTLE (apixaban), although some would suggest that apixaban performed best. Apixaban 5mg BID was superior to warfarin in stroke prevention, and caused fewer major/brain bleeds.

Edoxaban is eliminated by the kidneys and in the bile. Like Xarelto®, it should not be used where creatinine clearance (GFR) is less than 30ml/min. Apixaban seems a bit safer here as well, as it can be used at 25ml/min since the liver plays a greater role in its elimination. If renal function is excellent (>95ml/min – unusual in LTC), edoxaban is not recommended, as it is eliminated too quickly from the body, increasing stroke frequency.

Edoxaban can be used for DVT treatment (LU 444). A limitation here is that the patient must receive 5 – 10 days of an injectable product (e.g. Fragmin® or Lovenox®) before starting edoxaban. Apixaban and Xarelto® can be started immediately upon DVT recognition, without the need for injectable therapy.

The news is not all bad for this new med. Interactions are less common (similar to Pradaxa®) than with other NOACs (amiodarone and verapamil must be avoided) and food has no impact on its absorption. The dose is 30mg daily for residents weighing less than 60Kg or having a GFR of 30–50 ml/min, otherwise 60mg daily is used, up to a GFR of 95.

Returns from Hospital

Facilities using PCC or MED e-care have a *Three Month Review* (TMR) document built into the platform. While most facilities don't use the TMR from their eMAR provider, it is an excellent tool for return from hospital reconciliations.

The TMR contains all resident identification information, as well as diagnostic, allergy and diet data. It also has columns for the prescriber to indicate whether a medication is to be stopped, continued or held, as well as nurse signature fields for preparation and follow up.

In PCC, access the resident profile, and select Medication Review from the Reports dropdown menu. Choose "3" *Signature Lines* and check the *Primary Physician*, *Renew* and *Stop* boxes. In MED e-care, choose *Medication* and *Physician Review* from the resident profile, then check the *Show More than One Signature* box. In each case you have a current review that can be used to reconcile against the hospital discharge orders. P&P 3.01, *New Orders*, and 3.18, *Med Reconciliation*, have been updated to reflect the changes.

Generic Pradaxa®

Pradaxa® (dabigatran) is the first NOAC to go generic. It may be a good cost saving option to consider for those with good renal function.

Prepared by Randy Goodman
Board Certified Geriatric Pharmacist