Heparin: [illegible] thrombin, prevents PT→T & fibrinogen → fibrin

Arixtra: Factor XA inhibitor

Coumadin: Vit K antagonist II VII IX X protein C & S

	Lovenox (enoxaparin)	Heparin	Arixtra (fondiparinux)	Coumadin (warfarin)	Xarelto (rivaroxaban)	Eliquis (apixaban)	Pradaxa (dabigatran)
DVT Prophylaxis	40 mg QD	5000 units SC TID (or BID in cachectic/ ESRD)	2.5 mg SC QD	2-5 mg PO/IV QD x 2 d or 10 mg PO x 2d dose according to INR	10mg PO QD 12 d (knee) 35 d (hip)	2.5 mg PO BID for 35 d (hip) or 12 d (knee)	110 mg 1-4 hr s/p then 220 mg PO QD x 28 d
DVT/PE Treatment	1 mg/kg SC BID	80 units/kg bolus (loading dose) then 18 units/kg/ hr infusion	Weight based <50 kg : 5 mg SC QD 50-100 : 7.5 mg SC QD >100 : 10 Mg SC QD	Overlap Heparin + Warfarin for at least 5 days until desired INR (>2)	15 Mg BID for 1st 21 days then 20 mg QD w/ food	10 Mg BID for 7 days, then 5 mg BID	150 Mg PO BID (initial tx w/ parenteral anticoag for 5-10 d)
Stroke Prophylaxis/AFib	1 mg/kg SC BID	70 units/kg bolus then 15 units/kg/ hr infusion		Individualize based on INR (target 2.5-3)	20 mg PO QD in CrCl >50 15 Mg QD in CrCl <50 w/ dinner	5 mg PO BID (renal dose)	150 Mg PO BID CrCl > 30 75 Mg BID CrCl < 15
Dose Adjustment Criteria	adj. in renal dsyfx. CrCl < 30, 1 mg/kg daily	get baseline PTT, monitor Q6h for 1st 24 hr then monitor daily	CrCl 30-50 ↓ dose 40% CrCl < 30, DO NOT USE	may need lower dose for Asians, CYP2C9 gene variants, hepatic dose adj	lower dose in renal dysfx	1/2 dose if >80 yo Cr > 1.5 weight < 60 kg dont use if CrCl < 25	renal dose adj (lower)
MISC.	type of LMWH not as fast as Heparin no need to	fast on & off *antidote : protamine HIT, hyper K	monitor CBC, electrolytes, renal fx	FAB Four drug interactions - Flagyl, Amio, Bactrim, Fluconazole NO DOSE ADJ monitor INR	no reversal agent	Dont use w/ CYP3A4 inhibitors no monitoring needed	antidote : Idraucizumab (Praxbind)