

New Anticoagulation protocols for COVID patients

COVID patients experience coagulation changes requiring more aggressive anticoagulation. As a result there will be anticoagulation orders added to the COVID ordersets. They will drive the MD to order heparin or enoxaparin.

These order sets are going live on 4/24 and patients will be identified by MD/LIP as low, intermediate or high risk

▼ COVID-19 Anticoagulation: VTE Prevention and Treatment

Unless contraindicated, COVID rule out or positive patients should be plac

Contraindication to chemoprophylaxis:

- Bleeding
- Profound thrombocytopenia/coagulopathy with platelets below 25K or fibrinoge

No results found for: BMCDIMER

Lab Results

Component	Value	Date/Time
Gfr (Non African American)	5	12/08/21
Gfr (African American)	3	12/08/21

The patients care team will place the patient in one of the risk categories based on lab values (D-dimer) and clinical status (whether or not they have a VTE).

The corresponding prophylaxis or treatment will be ordered using either enoxaparin or unfractionated heparin (SQ or IV).

Once the risk profile is determined along with renal function (CrCL), an order set will be selected for the patient.

Enoxaparin and SQ heparin will be ordered once or twice a day or an unfractionated (UF) heparin infusion will be ordered. These are weight based protocols. The Heparin orders are the same ones you already use.

When UF Heparin is ordered, it may or may not be initiated with a bolus depending on the patients risk level and prior anticoagulation status. The dose will still be adjusted based on the patient's aPTT.

Caution: Physicians are being asked to assess patient's labs and clinical status daily. The patient may need to be changed to a more aggressive heparin orderset (e.g. from intermediate to high risk).

If a patient has been on anticoagulation and their status/risk has changed, there may be an increase or decrease in heparin ordered with or without a bolus.

***Pharmacy is available to discuss the treatment strategy with the team. The pharmacist will advise on the treatment strategy to use to attain the desired clinical and aPTT goals.

INTERMEDIATE RISK

Intermediate Risk: No VTE but D-dimer > 2,000

CrCL \geq 30 mL/min: Increased Intensity Enoxaparin Prophylaxis

CrCL < 30 mL/min: Unfractionated Heparin Infusion (No Bolus and Low aPTT Goal 45-65)

heparin infusion NO BOLUS Low (aPTT Goal: 45-65)

Heparin (NO BOLUS Low) 25,000 units in 250 mL (100 units/mL) infusion

Initial Infusion Rate (8 units/kg/hr): 1,200 units/hr aPTT <45 Increase infusion by 300 units/hr aPTT 45 units/hr aPTT >75 Hold infusion for 2 hours AND Decrease by 450 units/hr AND notify MD/LIP. MUST

HIGH RISK


CrCL < 30 mL/min: Unfractionated Heparin Infusion

heparin infusion for DVT/PE/arterial thrombosis (aPTT Goal: 55-90) BMI \geq 30

BMI based dosing is initiated with an infusion dose: 15 units/kg/hr on patients aPTT level

Heparin injection 10,000 Units

10,000 Units, Intravenous, Once, today at 1115, For 1 dose
Initial loading dose

 The original dose of **12,000 Units (80 Units/kg Once)** exceeded the recommended single dose limit of
The dose has been automatically changed to **10,000 Units.**

Heparin (DVT/PE/arterial thrombosis) 25,000 units in 250 mL (100 units/mL) infusion

Initial Dose: 2,250 units/hr Weight used: 04/23/20 : (!) 150 kg aPTT <40 Give BOLUS AND increase by 600 units/hr aPTT 55-90 No Change aPTT 91-150 Decrease by 300 units/hr aPTT >150 HOLD infusion for 1 hr
NOTIFY MD/LIP for 2 consecutive aPTT values outside of the goal aPTT range.

Interim aPTT Goal: 55-90

Anticoagulation in COVID-19 at BMC



** May continue prior anticoagulation regimen if deemed appropriate

²² May consider extended prophylaxis for 4 weeks upon discharge (potential agent such as apixaban 2.5 mg BID)