NHS
Surrey

Rivaroxaban Conversions

Conversion from warfarin to rivaroxaban

For patients treated for prevention of stroke, warfarin treatment should be stopped and rivaroxaban therapy should be initiated when the INR is 3.0 or less. When converting patients from warfarin to rivaroxaban, INR values will be falsely elevated after the intake of rivaroxaban. The INR is not valid to measure the anticoagulant activity of rivaroxaban, and therefore should not be used.

Conversion from rivaroxaban to warfarin

There is a potential for inadequate anticoagulation during the transition from rivaroxaban to warfarin. Continuous adequate anticoagulation should be ensured during any transition to an alternative anticoagulant. It should be noted that rivaroxaban can contribute to an elevated INR. Warfarin should be given concurrently with rivaroxaban until the INR is 2.0. For the first two days of the conversion period, standard initial dosing of warfarin should be used followed by warfarin dosing guided by INR testing.

Conversion from parenteral anticoagulants to rivaroxaban

For patients currently receiving a parenteral anticoagulant, rivaroxaban should be started 0 to 2 hours before the time of the next scheduled administration of parenteral medicinal product (e.g. LMWH) or at the time of discontinuation of a continuously administered parenteral medicinal product (e.g. intravenous unfractionated heparin).

Conversion from rivaroxaban to parenteral anticoagulants

Give the first dose of parenteral anticoagulant at the time the next rivaroxaban dose would have been taken.

Reference:
Summary of Product Characteristics for Xarelto: http://www.medicines.org.uk/EMC/medicine/25592/SPC/Xarelto+15mg+film-coated+tablets/