UMC Health System

ANTICOAGULATION REVERSAL PLAN

Patient Label Here

PHYSICIAN ORDERS

Diagnosis _____

Weight _____ **Allergies** _____

Place an "X" in the Orders column to designate orders of choice AND an "x" in the specific order detail box(es) where applicable.

ORDER	ORDER DETAILS
	Medications
	Medication sentences are per dose. You will need to calculate a total daily dose if needed.
	.Medication Management ☐ NOW, Start date T;N Contact provider to suggest discontinuing ALL anticoagulants (warfarin, heparin, low molecular weight heparins, factor Xa inhibitors, direct thrombin inhibitors, thrombolytic agents)
	Warfarin
	Warfarin Reversal Guidelines ☐ ***See Reference Text***
	Provider to place order to discontinue warfarin **phytonadione** ☐ 2.5 mg, PO, soln, ONE TIME ☐ 5 mg, PO, soln, ONE TIME ☐ 5 mg, IVPB, ivpb, ONE TIME, Infuse over 30 min Infuse over 30 minutes ☐ 10 mg, IVPB, ivpb, ONE TIME, Infuse over 60 min Infuse over 60 minutes
	prothrombin complex ☐ 25 units/kg, IVPush, inj, ONE TIME, for INR between 2 - 3.9 Maximum dose is 2,500 units Round dose to nearest vial ☐ 35 units/kg, IVPush, inj, ONE TIME, for INR between 4 - 6 Maximum dose is 3,500 units Round dose to nearest vial ☐ 50 units/kg, IVPush, inj, ONE TIME, for INR GREATER than 6 Maximum dose is 5,000 units Round dose to nearest vial
	BB Plasma for pts 25 kg or GREATER
	Prothrombin Time with INR
	Unfractionated Heparin
	Unfractionated Heparin Reversal Guidelin (Unfractionated Heparin Reversal Guidelines) ☐ ***See Reference Text***
	Provider to place order to discontinue heparin ***Refer to the Unfractionated Heparin Reversal Guidelines, for protamine dosing recommendations*** **protamine** ☐ Slow IVPush, inj, ONE TIME Administer over at least 10 minutes. Maximum recommended dose is 50 mg. Continued on next page....

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Order Taken by Signature: _____ Date _____ Time _____

Physician Signature: _____ **Date** _____ **Time** _____

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ORDER	ORDER DETAILS
	Notify Provider (Misc) ☐ Reason: Patient exhibits rash, shortness of breath, or any other signs of anaphylaxis.
	Anti Xa Level
	Low Molecular Weight Heparin
	Low Molecular Weight Heparin Reversal Gu (Low Molecular Weight Heparin Reversal Guidelines) ☐ ***See Reference Text***
	Provider to place order to discontinue low molecular weight heparin (ex: enoxaparin) ***Refer to the Low Molecular Weight Heparin Reversal Guidelines, for protamine dosing recommendations*** **protamine** ☐ Slow IVPush, inj, ONE TIME Administer over at least 10 minutes. Maximum recommended dose is 50 mg.
	If, 4 hours after initial dose of protamine, bleeding continues or aPTT is prolonged, may administer a second dose of protamine 0.5 mg for every 1 mg of enoxaparin ***Refer to the Low Molecular Weight Heparin Reversal Guidelines, for protamine dosing recommendations*** **protamine** ☐ Slow IVPush, inj, ONE TIME Administer over at least 10 minutes. Maximum recommended dose is 50 mg.
	PTT ☐ Routine, T;N+240
	Anti Xa Level
	Factor Xa Inhibitors
	Factor Xa Inhibitors Reversal Guidelines ☐ ***See Reference Text***
	Provider to place order to discontinue factor Xa inhibitor (ex: rivaroxaban, apixaban) **prothrombin complex** ☐ 50 units/kg, IVPush, inj, ONE TIME Maximum recommended dose is 5,000 units. Round dose to the nearest vial size.
	May use charcoal if ingestion of oral Factor Xa Inhibitor is within 1-2 hours of charcoal administration **charcoal** ☐ 25 g, PO, liq, ONE TIME Shake well. ☐ 50 g, PO, liq, ONE TIME Shake well. ☐ 100 g, PO, liq, ONE TIME Shake well.

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PHYSICIAN ORDERS	
Place an "X" in the Orders column to designate orders of choice AND an "x" in the specific order detail box(es) where applicable.	
ORDER	**ORDER DETAILS**
	Prothrombin Time with INR
	PTT
	IV Direct Thrombin Inhibitors
	IV Direct Thrombin Inhibitors Reversal G (IV Direct Thrombin Inhibitors Reversal Guidelines) ☐ ***See Reference Text***
	Provider to place order to discontinue IV Direct Thrombin Inhibitor (ex: argatroban, bivalirudin) **prothrombin complex** ☐ 50 units/kg, IVPush, inj, ONE TIME Maximum recommended dose is 5,000 units. Round dose to the nearest vial size.
	PTT
	Oral Direct Thrombin Inhibitors
	Oral Direct Thrombin Inhibitor Reversal (Oral Direct Thrombin Inhibitor Reversal Guidelines) ☐ ***See Reference Text***
	Provider to place order to discontinue oral direct thrombin inhibitor (ex: dabigatran) **idaruCIZUmab** ☐ 2.5 g, IVPB, ivpb, q15min, x 2 dose, Infuse over 10 min
	If significant bleeding with elevated coagulation parameters persists after initial dose of idaruCIZUMAB (Praxbind), may consider administration of an additional 5 gram dose (given as 2 separate doses of 2.5 g each) of idaruCIZUMAB* **idaruCIZUmab** ☐ 2.5 g, IVPB, ivpb, q15min, x 2 dose, Infuse over 10 min
	May use charcoal if ingestion of oral DTI is within 1-2 hours of charcoal administration. **charcoal** ☐ 25 g, PO, liq, ONE TIME Shake well. ☐ 50 g, PO, liq, ONE TIME Shake well. ☐ 100 g, PO, liq, ONE TIME Shake well.
	PTT
	Alteplase or Other Thrombolytic Agent
	Alteplase or Other Thrombolytic Agent Re (Alteplase or Other Thrombolytic Agent Reversal Guidelines) ☐ ***See Reference Text***
	Provider to place order to discontinue alteplase (tPA) or other thrombolytic agent **BB Platelet for pts 25 kg or GREATER**
	BB Cryoprecipitate for pts 25 kg or GREA (BB Cryoprecipitate for pts 25 kg or GREATER)
	aminocaproic acid should ONLY be used IF ICH increases in size despite platelet and cryoprecipitate infusions **aminocaproic acid** ☐ 5 g, IVPB, ivpb, ONE TIME, Infuse over 1 hr

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ORDER	**ORDER DETAILS**
	aminocaproic acid 8 g/400 mL NS ☐ IV Final concentration = 20 mg/mL. ☐ Start at rate:_____g/hr
	Fibrinogen Level
	PTT
	Prothrombin Time with INR

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