Warfarin Reversal Guidelines

<table>
<tr><th>Condition</th><th>Recommendation</th></tr>
<tr><td>Greater than goal INR but less than 4.5 without bleeding</td><td>Decrease dose OR hold dose, then resume at a lower dose when INR is within therapeutic range. If INR is only minimally above therapeutic range, may continue current dosage. Increase frequency of INR monitoring.</td></tr>
<tr><td>INR 4.5 – 10 without bleeding</td><td>Hold next one or two doses of warfarin, then resume at a lower dose when INR is within therapeutic range. Routine use of phytonadione (vitamin K) is not recommended unless patient is at high risk of bleeding. Increase frequency of INR monitoring.</td></tr>
<tr><td>INR greater than 10 without bleeding</td><td>Hold warfarin and give phytonadione (vitamin K) 2.5 - 5 mg by mouth, may repeat every 24 – 48 hours as needed. Resume warfarin at a decreased dose when INR is within therapeutic range. Increase frequency of INR monitoring.</td></tr>
<tr><td>Serious bleeding at any elevation of INR</td><td>Hold warfarin. Give phytonadione (vitamin K) 5 - 10 mg IVPB AND prothrombin complex (Kcentra), see dosing recommendations below

Dosing recommendations for prothrombin complex (Kcentra) expressed in units of factor IX activity. Round dose to the nearest vial size.

<table>
<tr><th>Pre-treatment INR</th><th>Between 2 – 3.9</th><th>Between 4 – 6</th><th>GREATER than 6</th></tr>
<tr><td>Dose of prothrombin complex (units of factor IX)</td><td>25 units/kg</td><td>35 units/kg</td><td>50 units/kg</td></tr>
<tr><td>Maximum dose (units of factor IX)</td><td>Not to exceed 2,500 units</td><td>Not to exceed 3,500 units</td><td>Not to exceed 5,000 units</td></tr>
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FFP 10 - 20 mL/kg or 2 units (use if prothrombin complex not available)</td></tr>
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Source: UMC Pharmacy Version: 1 Reviewed: 04/06/2016