NHS
Cheshire and Merseyside

Switching Edoxaban to Apixaban in adults with non-valvular AF

Clinical Protocol

Version 1.0

[February 2026]

This clinical protocol is intended for use by Medicines Management Teams and GP practices across Cheshire and Merseyside ICB and should be used in conjunction with place standard operating procedures/practice work guidelines

Rationale

This programme aims to switch patients across the ICB to the most cost-effective Direct Oral Anticoagulant (DOAC). The initiative will deliver significant in-year financial savings, including reductions in Trust expenditure on DOACs, and will be further supported through ICB-wide prescribing incentives.

As part of the switch, each patient will undergo a clinical review, including assessment of renal function and body weight, to ensure the correct DOAC and dose are selected. This process is expected to result in quality improvements, as it provides an opportunity to optimise anticoagulation therapy, address any safety issues, and ensure up-to-date monitoring.

This will be a large-scale primary care–led switching programme, supported by system-wide communications, clinical guidance, and monitoring to ensure safe, consistent, and efficient delivery.

Drug Tariff February 2026

DOAC	Quantity	Monthly Cost
Edoxaban 30mg	28	£49.00
Edoxaban 60mg	28	£49.00
Edoxaban 15mg	10	£17.50
Apixaban 2.5mg	60	£1.03
Apixaban 5mg	56	£1.09

Formulary Status

Edoxaban and Apixaban for the treatment of Non-Valvular AF **- Green**

Clinical system templates

On Emis three templates should be used

1. Estimated creatinine clearance (Cockcroft and Gault)
2. AF Advisor
3. DOAC medication Review

Who can work under this protocol

	Please add X
Clinical Pharmacist	x
Technician	
Medicines Co-ordinator	
GP (can be delegated if GP feels appropriate)	x

Inclusion Criteria

All patients 18 years and over prescribed Edoxaban for non-valvular AF

Exclusion Criteria

- Patients <18 years of age
- End of life/palliative patients
- Patients previously prescribed Apixaban and stopped due to documented:
  - intolerance, allergy or adverse drug reaction to Apixaban and/or excipients
  - treatment failure

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	• Taking Edoxaban for another indication or for off-licence use started under a specialist • Previous poor concordance with twice daily dosing of a DOAC • Patient suffering with active clinically significant bleeding. [1][3] • Patients with hepatic disease associated with coagulopathy and clinically relevant bleeding risk [1][3] • Lesion or conditions considered a significant risk factor for major bleeding [1][3] • Concomitant treatment with any other anticoagulant agent [1][3]
Method	This protocol is taken from 36.-2025-SOP-Cheshire-and-Mersey-Medicine-optimisation-of-DOACs.pdf • Check the patient doesn't fit any exclusion criteria • Check the indication for the DOAC • Open consultation **Open estimated creatinine clearance (Cockcroft and Gault) Template (EMIS)** • Confirm both weight and bloods including FBC, U+E, serum creatinine and LFT have been recorded in the **last 6 months** and calculate creatinine clearance using actual body weight • For patients who are >75 years old or frail confirm both weight and bloods including FBC, U+E, serum creatinine and LFT have been recorded in the **last 4 months** and calculate creatinine clearance using actual body weight • For patients with an intercurrent illness that may impact liver or renal function i.e. infection, decompensated heart failure confirm both weight and bloods including FBC, U+E and LFT have been recorded in the **last 4 months** and calculate creatinine clearance using actual body weight Pts with CrCl < 15mls/min – refer to GP for review as DOACs contraindicated. [2] If CrCl borderline (15 – 20mls/min) this should be discussed with GP to ensure a DOAC is still appropriate • Close template and save consultation • Open new consultation **Open AF Advisor template (EMIS)** • Calculate and update the CHA2DS2-VASc score *Patients with a CHA2DS2-VASc =1 in men or =2 in women should be considered for an oral anticoagulant (DOAC).* *Patients with a CHA2DS2-VASc score >2 in men and >3 in women: It is recommended that these patients should be prescribed a DOAC.* [4] • Calculate and update the HAS-BLED/ORBIT score ○ Refer to GP if clarification needed for modification, monitoring or advice, if there is no documentation that the following risk factors have been considered:

	▪ Uncontrolled hypertension ▪ Concurrent medication that will increase bleeding risk ▪ Anti-platelet medication e.g. aspirin ▪ Non-steroidal anti-inflammatory drugs (NSAIDs) ▪ SSRI's or SNRI's ▪ Harmful alcohol consumption above national recommendations (if noted on PMR) ▪ reversible causes of anaemia *A high bleeding risk score should generally not result in withholding DOAC. Rather, bleeding risk factors should be identified and treatable factors corrected.* • *If patients are on concomitant anti-platelets, review if these are appropriate. Consider stopping if >1-year post-acute coronary syndrome (ACS) or stable coronary artery disease. Discuss with GP/Specialist if necessary.* • *Consider gastro-protection with appropriate concomitant anti-platelets* Confirm if the current DOAC dose is appropriate according to current parameters (the AF advisor template will support this) – see Appendix 1 and SPC. • Check all medication for any significant drug interactions including hospital prescribed medication, OTC and herbal/alternative therapy see BNF and SPCs for full details NB: Where the efficacy of either the DOAC or another medication is affected please ensure this is discussed with the GP and/or relevant specialist e.g. antiepileptics • Discuss any patients on incorrect dose, significant interactions, safety concerns with GP. **Open DOAC Medication Review template (EMIS)** Patients can be contacted via telephone or face to face • Add code 'Medication review done by Medicines Management Pharmacist' SNOMED CODE [**961831000000100]** (if ICB Pharmacist completing) • Work through the template discussing: o GI symptoms (consider addition of PPI or discuss with GP) o Swallowing difficulties o Bleeding o OTC or herbal medications o Adherence o Adverse drug reactions o Side-effects o Excessive alcohol intake (if significantly different to what was recorded may need to r*e-calculate HASBLED/ORBIT score)*

<table>
<tr><td></td><td>

Follow the Clinical system template and cover the key questions and counselling points with the patient and/or carer BEFORE considering change to Apixaban – see Appendix 2
Discuss any issues/concerns identified with GP

Switching from Edoxaban to Apixaban

Utilise the ‘Decision aid to switch to Apixaban guide’ to decide if patient is suitable for the switch – see Appendix 3
Explain to the patient that we will be switching their Edoxaban to Apixaban, this is because Apixaban is now first line according to national guidance and the Cheshire and Merseyside ICB formulary
If patient suitable code in consultation ‘Drug changed to cost effective alternative’ with note ‘Changed to Apixaban in line with NHSE and C&M ICB guidance’
Document patient/carer advised to stop current DOAC and start Apixaban when next dose of DOAC is due
End the course of Edoxaban with reason ‘Changed to Apixaban in line with NHSE and C&M ICB guidance’
Following the consultation send a text message or email to the patient with a link to this leaflet Apixaban PIL (see communication templates section)
Set the monitoring follow up date to the appropriate time interval according to renal function (see monitoring and follow up section)
If patient uses a monitored dosage system inform community pharmacy of any changes.
If patient not suitable for switch code in consultation ‘Cost effective alternative not considered’ with note ‘Reviewed in line with NHSE and Cheshire and Merseyside ICB guidance Patient unsuitable for switch to Apixaban’.

</td></tr>
<tr><td>Monitoring and follow up</td><td>
Blood monitoring required for DOACs (Steffel et al., 2021)

Full blood count
Liver function tests
Urea and electrolytes
Serum creatinine (for creatinine clearance)

<table>
<tr><th colspan="2">Monitoring</th></tr>
<tr><th>Interval</th><th>Patient Cohort</th></tr>
<tr><td>Yearly</td><td>Patients other than those specified below</td></tr>
<tr><td>4 – monthly</td><td>≥75 years (especially if on dabigatran) or frail</td></tr>
<tr><td>Variable X - monthly</td><td>If renal function CrCl ≤60 mL/min: recheck interval = CrCl/10 (= X months)</td></tr>
<tr><td>If needed</td><td>Any intercurrent condition that may impact renal or hepatic function as identified by the GP/NMP</td></tr>
</table>
</td></tr>
<tr><td>Communication Templates</td><td>SMS/Tasks</td></tr>
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	Dear XX Following your consultation today, your Edoxaban X mg has changed to Apixaban X mg twice a day. You should continue to take your Edoxaban Xmg before switching to Apixaban, which you can order in your next repeat prescription. Please start taking the Apixaban when the next dose of your anticoagulant is due. Apixaban PIL If you have any questions about this change, please contact XXX
Scriptswitch message	
Stock assurance	
Communications with other healthcare professionals	
References	1. Apixaban SPC accessed via EMC 16/2/2026 https://www.medicines.org.uk/emc/product/100229/smpc#gref 2. DOACs (Direct Oral Anticoagulants) monitoring – NHS SPS - Specialist Pharmacy Service – The first stop for professional medicines advice 3. Edoxaban SPC accessed via EMC 16/2/26 Lixiana 15mg Film-Coated Tablets - Summary of Product Characteristics (SmPC) - (emc) | 6907 4. Quality statement 1: Anticoagulation to reduce stroke risk | Atrial fibrillation | Quality standards | NICE

Appendix 1

Doses of Apixaban [2] and Edoxaban [3]

	Apixaban	**Edoxaban**
Standard dose	**5mg twice daily**	**60mg daily**

Reduce dose in the following patients	**2.5mg twice daily** If CrCl 15-29ml/min **OR** 2 of the following criteria: - ≥80yrs - Creatinine ≥133mmol/l - Weight ≤60kg	**30mg daily** - CrCl ≤50ml/min - Weight ≤60kg - On interacting medication (Ciclosporin, dronedarone, erythromycin, ketoconazole)

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Appendix 2

Medicine Optimisation Reviews for DOACs in AF – Patient/Carer Contacted - Consultation Checklist

Counselling point **before** starting review
Explain that all patients with non-valvular Atrial Fibrillation who are prescribed a DOAC for stroke prevention are being reviewed to ensure it is appropriate and the correct dose. No need for alarm or concern.

Follow the **EMIS Template** and cover these key questions and counselling points with the patient and/or carer **BEFORE** considering changes to DOAC treatment

Question\Counselling Point	
Check adherence with DOAC treatment.	Ensure the patient is aware of the importance of adherence with these medications.
Check if the patient has experienced any ADRs or side effects.	Report via yellow card scheme where necessary and update the clinical record. Seek advice from GP or specialist if needed.
"Do you suffer with any symptoms such as: acid reflux, heartburn, stomach pains etc.?"	Is the patient taking gastro protection medication regularly? Refer to the GP for gastro protection if not already prescribed or if already prescribed gastro protection and still symptomatic
"Any current symptoms of bleeding?"	Ensure patient knows the signs to be aware of and to contact their GP or, if severe, to go straight to hospital or call an ambulance. Bruising or bleeding under the skin • Blood in the urine • Coughing up blood • Vomiting blood or material that looks like ground coffee • Nose bleeds or cuts that take a long time to stop bleeding • Tar-coloured stools • Dizziness or sudden headache • Unexplained tiredness • Abnormal vaginal bleeding, including heavier or prolonged menses •new confusion
"Any swallowing problems with tablets?"	Apixaban and Edoxaban tablets can be crushed and mixed with water, apple juice or apple puree. Patients with long term swallowing problems should remain on apixaban or Edoxaban.
"Are you taking any other medication (e.g. from the hospital), OTC or herbal medicines?"	For example, Aspirin, NSAIDS, St. John's Wort etc. ensure the patient is aware to always check with a pharmacist before using any OTC or herbal meds due to risk of interactions with anticoagulants.
Check on alcohol consumption - Re-calculate HAS-BLED/ORBIT score as needed.	If appropriate, remind patient of current government guidelines; no more than 14 units of alcohol per week for men and women spread over at least 3 days with several alcohol-free days per week.

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"Have you ever had a blood clot? Or been told you have a blood clotting problem?"	This is to check any history of DVT or PE (including any unusual clots such as LV thrombus or portal vein thrombosis) or any thrombophilia that may not have been recorded on the PMR. This would highlight if the patient is on a DOAC for an off-license use (LV thrombus) or requires a different dose e.g. DVT/PE Note: only arterial clots are considered as a thromboembolism when calculating CHA_2DS_2-VASc (excludes DVT/PE), but this may highlight different dose requirement
"Have you ever had an operation on your heart?"	This is to check if the patient may have had a mechanical heart valve replacement or valve repair that has not been recorded on the PMR which may contraindicate treatment of any DOAC.
IF APPROPRIATE: Check if the patient is pregnant or breastfeeding	DOACs are normally contraindicated during pregnancy and women of child-bearing potential should avoid becoming pregnant during treatment. Advise to use reliable contraception and discuss with the GP if planning pregnancy. DOACs also normally contraindicated during breastfeeding, it should be decided whether to cease therapy or to discontinue breastfeeding. Seek specialist advice from haematology if pregnant or breastfeeding.
Explain decision to change patient to another DOAC or change the dose of existing therapy if relevant	Advise patient of necessary changes and why. If DOAC agent changing to alternative, explain the rationale There is a PIL available to support this discussion.
If further advice is needed from a specialist outside of the GP practice gain patient consent to discuss	Patients already discussed with the GP, but who need further information, advice may be sought from a secondary care specialist pharmacist who may discuss with a Cardiologist if necessary. This will require documented patient consent. Complicated patients can be referred to the Specialist AF Clinic at LHCH.

Counselling points	After decision of DOAC change
If DOAC treatment to be changed	If a DOAC is going to be changed to an alternative DOAC, assure the patient that the new DOAC will have the same beneficial effect as their current anticoagulant and their risk of stroke due to AF will be controlled in the same way as before. A patient information leaflet has been developed to guide this discussion. Explain that their full history and medication have been reviewed and the new DOAC is appropriate and most cost-effective.
Changing from one DOAC to another	When changing from one DOAC to another advise the patient to use up the remainder of their existing DOAC first. It is important that the new DOAC is started when the NEXT dose was due of the ORIGINAL DOAC. The dose should then be continued as labelled (see below for how change in DOAC directions should be explained to each patient with written instructions). **Once daily DOAC to twice daily DOAC:**

	Finish the last dose of the existing once daily DOAC and start the new DOAC 24 hours later then continue taking the new DOAC every 12 hours twice a day
Dosage and Directions	Clearly explain the dosage and directions of the DOAC. Apixaban and Edoxaban can be taken **with or without food**, should be swallowed whole and not chewed Edoxaban have **ONCE daily administration** and Apixaban **TWICE daily**. Explain importance of good adherence to medication.
Missed Dose	Explain the the importance of good adherence. Explain that to ensure optimal protection from blood clots, never skip a dose and **DO NOT** stop taking unless advised by the prescribing. If a dose of Apixaban is missed, the patient should take apixaban immediately and then continue with twice daily intake as before. If the patient misses a dose of Edoxaban they should take it immediately and then continue the following day with the once-daily intake as recommended. The patient should **not** take double the prescribed dose on the same day to make up for a missed dose.
General additional advice for DOACs	It is important that patients inform other health professionals treating them, including their dentist and pharmacist, that they are taking this medicine. Inform a healthcare specialist if they need to have surgery or an invasive procedure. Patients should seek urgent medical attention if they fall or injure themselves during treatment, especially if they hit their head, due to the increased risk of bleeding. Lifestyle advice regarding contact sports or extreme sports should be included in the counseling where appropriate as an injury whilst taking a DOAC could cause serious bruising or bleeding.
Reversal Agents	There are reversal agents available which can be used in severe bleeding or if emergency surgery/procedure is required in an emergency under specific circumstances. See the SOP for further details.
Alert Card	Advise the patient/carer to always carry their alert card (supplied with medication) and always inform health professionals that they are taking an anticoagulant prior to any procedure.
Weight change	Advise that the patient should inform their GP about any significant weight change that results in their body weight going **above 60kg (9st 6.3lb) or below 61kg (9st 8.5lb)** as their dose may need to be changed.
Monitored Dosage System?	Check if patient uses a monitored dosage system and inform the community pharmacy if any change to treatment is required.

Appendix 3

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1. Consideration to switch from an existing DOAC to apixaban in adults with non-valvular atrial fibrillation (AF)

2. Do any of the following criteria apply?

- Known hypersensitivity to apixaban or any of the excipients
- Taking current DOAC for another indication or for off-licence use started under a specialist
- Currently on dabigatran 150mg twice daily due to recurrent ischaemic stroke /systemic embolism/TIA despite good anticoagulation control (TTR≥70%) or other DOAC
- Previous poor concordance with twice daily dosing of a DOAC

Yes

Continue existing DOAC at the appropriate dose

- **Edoxaban 60mg daily** or **edoxaban 30mg daily if:**
  - Weight ≤60kg
  - CrCl 15-50[a]ml/min
  - On strong P-gp inhibitor

Or

- **Rivaroxaban 20mg daily** or **rivaroxaban 15mg daily** if CrCl <50mls/min

Or

- **Dabigatran 150mg BD or dabigatran 110mg BD if:**
  - Age ≥80 years old
  - Age 75-79 years and bleeding risk high
  - Weight <50kg
  - CrCl 30-50ml/min (alternative agent preferred)
  - Concomitant verapamil
  - High bleeding risk

No

- Use recent* weight and creatine to estimate Creatinine Clearance (CrCl)
- Consider contraindications and interactions**
- Refer to protocol for DOACs in AF and FAQ and SPC for apixaban

- Arrange a consultation to discuss anticoagulation options and establish whether the individual is suitable for a switch to apixaban. Use clinical risk profiles and personal preferences to guide treatment choices
- Individuals who consent to the switch should be educated accordingly. A PIL is available to support changes to anticoagulation

- Advise to use up the supply of their existing DOAC before switching to the apixaban, starting apixaban when the next dose of DOAC is due
- Provide a PIL for apixaban
- **Initiate apixaban 5mg BD** or
- **Apixaban 2.5mg BD if** your patient meets the following criteria:
  - CrCl 15-29 ml/min

  OR if your patient has at least TWO of the following risk factors:
  - Age ≥80 years old
  - Weight ≤60kg
  - Serum creatinine ≥ 133 micromole/L
- Consider when repeat renal function is due to be monitored (refer to protocol)

NOTE:
*At initiation of apixaban treatment (new or switching), both weight and renal function should have been confirmed within the last 6 months unless:
- Patients who are >75 years old or frail should have a more recent weight and renal function checked within 4 months.
- Patients with an intercurrent illness that may impact liver or renal function should have bloods checked within 4 months.

**CrCl<20mls/min consider if OAC appropriate
See 'Initiating a DOAC Decision Aid' for abbreviation key