Cheshire Medical Center
Dartmouth-Hitchcock Keene

Warfarin (Coumadin) New Start Protocol – Outpatient

Goal INR:
2.0 – 3.0

- Recommend initial warfarin dose of 10 mg daily times 2 days. (this may be reduced to 5mg for the elderly, those with impaired nutrition, liver disease, CHF, or bleeding risk)
- Check INR on day 3
- Check INR ever other day until therapeutic range is reached times 2.

Based on 10 mg start:
Starting on day 3, the following nomogram is used at each pt/inr check:
INR <1.39 = 10mg
INR 1.40 to 1.89 = 7.5mg
INR 1.90 to 2.39 = 5mg
INR 2.40 to 2.89 = 2.5mg
INR > 2.90 = 0mg and recheck in 1-2 days

- After the **second consecutive** therapeutic INR is achieved, a weekly dose can be calculated.

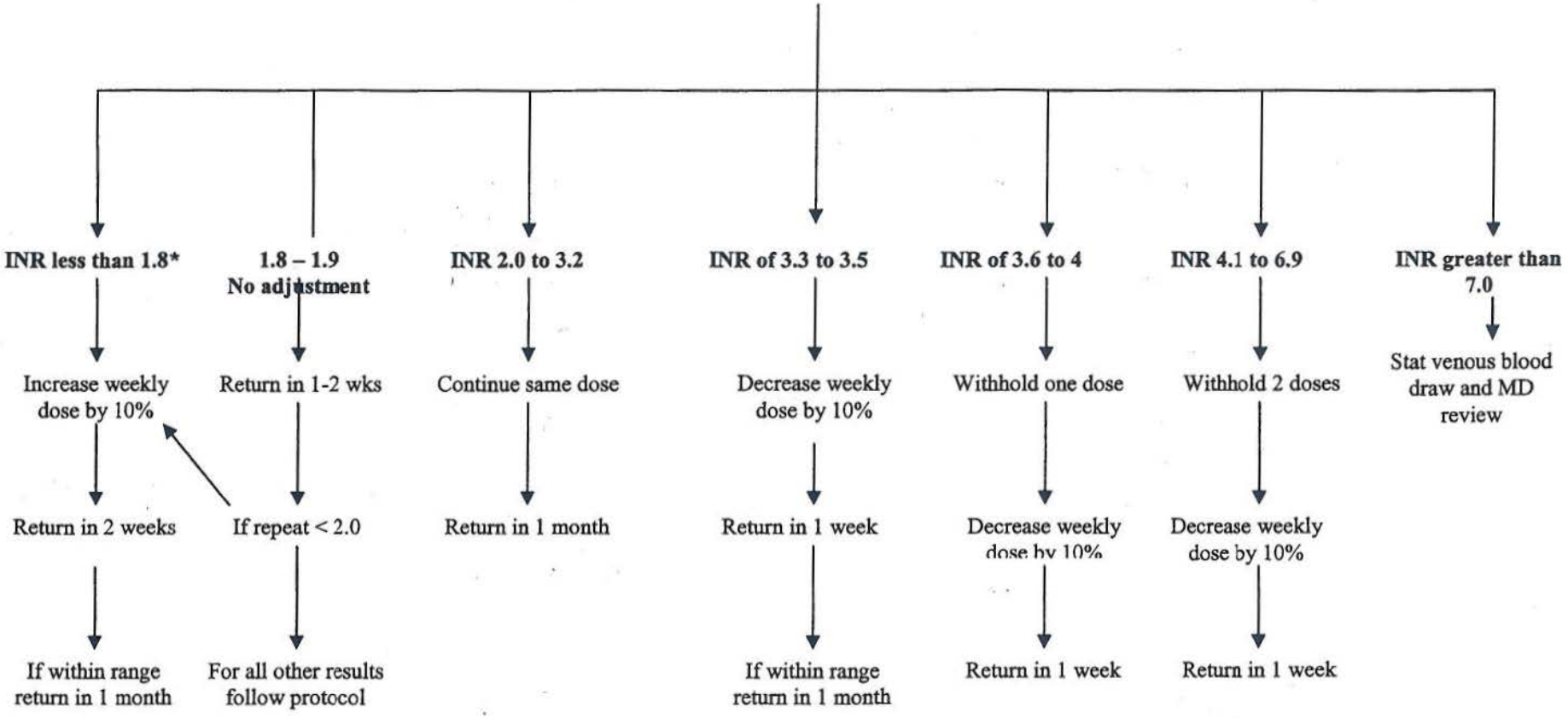
- Pt should return for next INR in one week. If patients INR is in range, he /she should continue with no change in warfarin dose plan and be scheduled for next INR in one week. Gradually schedule to 2 weeks out and then four weeks if in range and no change in warfarin dose is made.

- If >7 days until a 2nd therapeutic INR is reached, use the most recent 7 days of dosing for your weekly calculation.

Andrew Tremblay, MD
Medical Director, Nurse Clinic

Approved by Clinical Monitoring on 11-10-09
Revised on 12/7/09, 6-15-12

ALTERING WARFARIN DOSAGE TO ACHIEVE INR OF 2 TO 3
(ACCEPTABLE RANGE 1.8-3.2)
Revised January 2009, September 2010



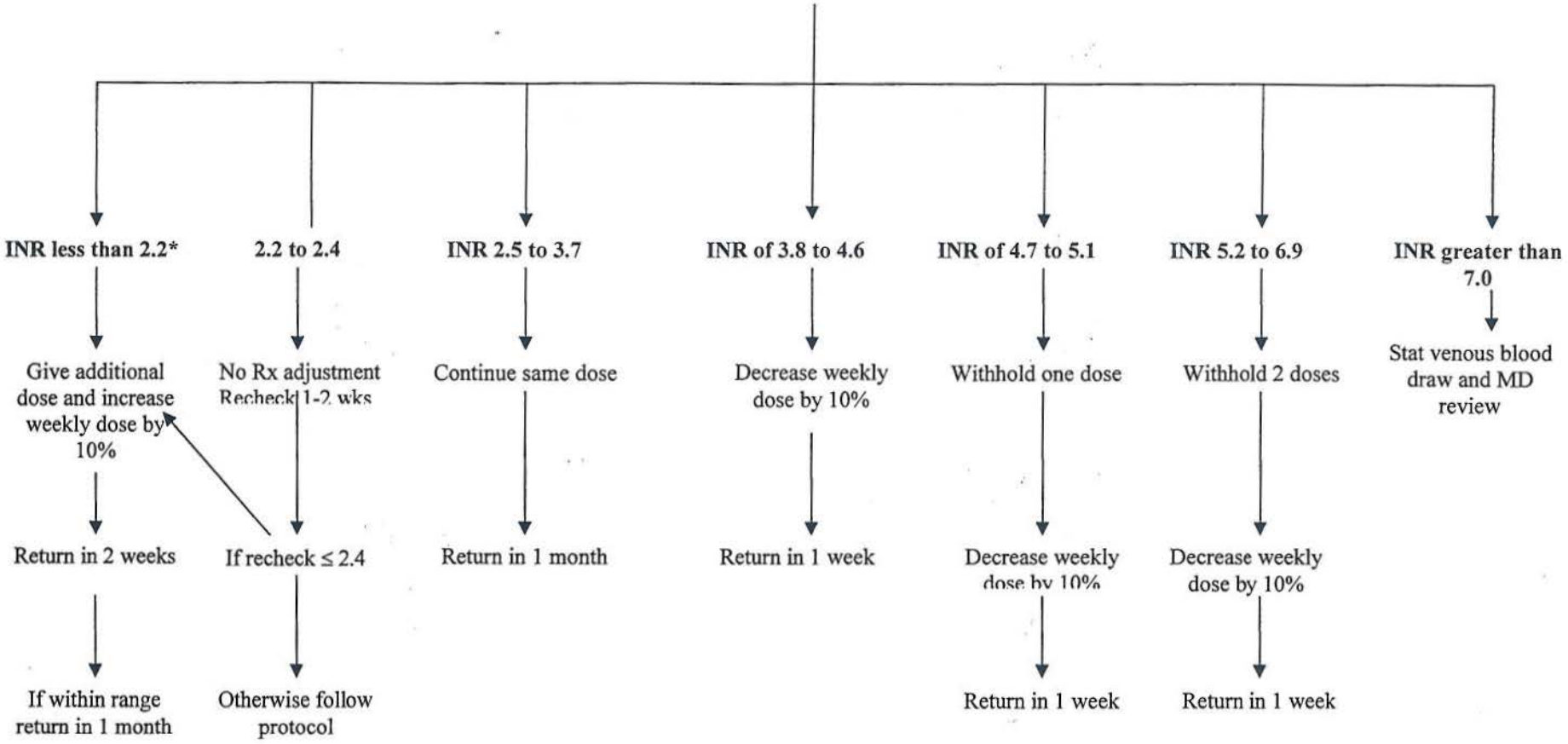
*Please review with patient any possible changes in their routine which may have affected their change in INR (i.e. diet/medication or a missed dose). If the cause of the drop in INR can be determined, resume or adjust Coumadin dose accordingly.

1. In calculating dose changes, the goal is to maintain consistency in prescription strength. Therefore, nurses should take into consideration patient results, patient hx, and strength of pill on hand when rounding up or down.
2. Doses are changed per protocol. If the pt cannot be managed by protocol (which is signed off by the medical director) then Nsg contacts an ordering provider, gets an order to adjust outside of the protocol and the note goes back to the ordering provider.
2. For Venous results round down to nearest 10^{th} for .01-.04 and round up to nearest 10^{th} for .05-.09
3. The MD can be consulted at any point during this protocol – per nurses judgment.

Approved

Andrew Tremblay, MD – Medical Director

ALTERING WARFARIN DOSAGE TO ACHIEVE INR OF 2.5 TO 3.5
(ACCEPTABLE RANGE 2.2-3.7)



*Please review with patient any possible changes in their routine which may have affected their change in INR (i.e. diet/medication or a missed dose). If the cause of the drop in INR can be determined, resume or adjust Coumadin dose accordingly.

1. In calculating dose changes, the goal is to maintain consistency in prescription strength. Therefore, nurses should take into consideration patient results, patient hx, and strength of pill on hand when rounding up or down.
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Approved _____

Andrew Tremblay, MD
Medical Director

Revised: 1/2009, 6/2012