

Anticoagulation in COVID-19 at BMC

Standard DVT Prophylaxis

- Admission with Asymptomatic COVID or Incidental COVID diagnosis
- Admitted directly to the ICU or severe COVID (requiring >20L high flow oxygen, non-invasive ventilation, intubation, or use of vasopressors)*
- No clinical evidence or concern for VTE/clotting and no other indication for anticoagulation.
- No bleeding or profound thrombocytopenia or coagulopathy with platelets < 25K or fibrinogen <0.5

CrCL ≥ 30mL/min

Standard Intensity Enoxaparin Prophylaxis

- 40 mg once daily for BMI ≤40 and weight <120kg
- 40 mg twice daily for BMI >40 or weight >120kg

CrCL < 30mL/min

Unfractionated SQ Heparin Prophylaxis

- 5,000 units three times daily for BMI ≤40 and weight <120kg
- 7,500 units three times daily for BMI >40 or weight >120kg

*Preliminary data suggests a benefit of therapeutic anticoagulation in Symptomatic COVID patients requiring non-ICU level of care on preventing progression to requiring organ support (ventilator support or vasopressors)

Full Dose Anticoagulation

- Admission with Symptomatic COVID without critical illness (requiring < 20L high flow oxygen with no need for ventilatory support or vasopressors) and *acceptable bleeding risk***
- Confirmed VTE or high clinical suspicion for VTE but unable to obtain confirmatory testing
- Established reason for therapeutic AC (Afib, prosthetic valve, etc.)**
- HD/CVVHD with clotting of dialysis tubing or lines resulting in repeated interruptions of therapy

CrCL ≥ 30mL/min

Full Anticoagulation with Enoxaparin

- 1 mg/kg twice daily

CrCL < 30mL/min

Unfractionated Heparin Infusion

- (Bolus and Standard aPTT Goal 55-90)
- 80 units/kg bolus then infusion of 18 units/kg/hr for BMI <30 or 15 units/kg/hr for BMI >30
 - Consider **Anti-Xa level** if poor response to treatment or additional thrombosis suspected

** May continue outpatient anticoagulation regimen if deemed appropriate.

May continue therapeutic anticoagulation if transferring from the floor to the ICU