Anticoagulation in COVID-19 at BMC

Low Risk

- **No clinical evidence or concern for VTE/clotting and no other indication for anticoagulation.**
- **D-dimer < 2,000 ng/mL**
- No bleeding or profound thrombocytopenia (with platelets below 25K) or severe coagulopathy

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 twice daily for BMI ≤40 and weight <120kg
- 7,500 units twice daily for BMI >40 or weight >120kg

Consider trending D-dimer and repeat risk stratification daily

Intermediate Risk##

- **Very high D-dimer ≥ 2,000 ng/mL (exceeds 8 times ULN of BMC assay)**

CrCL ≥ 30mL/min → **Increased Intensity Enoxaparin Prophylaxis**

- 0.5 mg/kg twice daily (with maximum dose of 70 mg twice daily for >130 kg)

CrCL < 30mL/min → **Unfractionated Heparin Infusion**

(No Bolus and Low aPTT Goal 45-65)

- No bolus with infusion of 8 units/kg/hr

ICU patients at intermediate risk: Consider screen for DVT with POCUS

Pregnancy: Use BMC's OB VTE order set plus consider 3-6 weeks of prophylactic enoxaparin for symptomatic COVID postpartum patients

High Risk/Full AC

- **Confirmed VTE**
- **Established reason for therapeutic AC (Afib, prosthetic valve, etc.)****
- **HD/CVVHD with clotting of dialysis tubing or lines resulting in repeated interruptions of therapy**
- **High clinical concern for DVT/PE but unstable/ otherwise unable to undergo confirmatory testing**

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)

- If not on anticoagulation, 80 units/kg bolus then infusion of 18 units/kg/hr for BMI <30 or 15 units/kg/hr for BMI >30
- If currently on anticoagulation or transitioning from Intermediate to High Risk consider consulting Pharmacy *(page 9825 off hours)* to determine appropriate adjustment

Consider VTE screening in patients with rapid increases in D-dimer (≥ 5-fold in 48 hours) or acutely worsening oxygenation/ increased dead space. Consider empiric anti-coagulation if low bleeding risk

**** May continue prior anticoagulation regimen if deemed appropriate**

May consider extended prophylaxis for 4 weeks upon discharge (potential agent such as apixaban 2.5 mg BID)

COVID Risk Based Order Set Options

COVID-19 Anticoagulation: VTE Prevention and Treatment

Unless contraindicated, COVID rule out or positive patients should be placed on enoxaparin.

Contraindication to chemoprophylaxis:
- Bleeding
- Profound thrombocytopenia/coagulopathy with platelets below 25K or fibrinogen < 0.5

○ Low Risk: No VTE and D-dimer < 2,000

○ Intermediate Risk: No VTE but D-dimer > 2,000

○ High Risk: Confirmed or suspected VTE or other reason for systemic anticoagulation

Intermediate Risk Order Set for CrCL ≥ 30

◉ Intermediate Risk: No VTE but D-dimer > 2,000

◉ CrCL >= 30 mL/min: Increased Intensity Enoxaparin Prophylaxis

Enoxaparin treatment dosing is based on actual body weight (ABW) and must be renally adjusted. For more information on dosing, please see Therapeutic Anticoagulation medication guideline.

☑ enoxaparin syringe 0.5 mg/kg

0.5 mg/kg, Subcutaneous, Every 12 hours, First Dose today at 1715
Indication: Other (please specify)
Reason: COVI-19: VTE Intermediate Risk
Until Discontinued