

NWOCC ANTI-COAGULATION CLINIC DOSING ALGORITHM: INR 2.0 - 3.0 (Goal 2.5)

INR	ACTION
≤ 1.5	Increase weekly dose by 15%; repeat INR in 7 - 10 days, notify physician if ≤ 1.5 more than twice in a row
1.51 - 1.99	Increase weekly dose by 10%; repeat INR in 7 - 10 days
2.00 - 3.00*	No change. Re-check INR in 4 weeks. If last result abnormal, re-check in 2 weeks.
3.01 - 5.99	If INR 3.01 - 3.5 do not hold warfarin If high on 2 consecutive occasions, decrease weekly dose by 10%. Repeat INR in 7 - 10 days. If INR 3.5 - 3.99 decrease dose by 5% and recheck in 7 - 10 days. If INR 4.00 - 4.99 hold for 1 day. Repeat INR in 7 - 10 days. Decrease dose by 10%. If INR 5.00 - 5.99 hold for 2 days. Repeat INR in 7 - 10 days. Decrease dose by 10%.
6.00 - 8.99	Hold Coumadin 2 days; recheck on 3 rd day. Restart at lower dose (decrease weekly dose by 15%) when INR therapeutic. Check INR weekly until stable. Consider Vitamin K 1 - 2.5 mg PO if at increased risk of bleeding. Inform physician.
≥ 9.0	Inform physician. Hold Coumadin per MD order. Consider Vitamin K 3 - 5 mg PO
> 18 or if serious bleeding regardless of INR	Inform physician immediately. Send patient to Emergency Room.

* If INR between 3.00 - 3.20, consider no change in dose with repeat INR in 7 - 10 days.

The clinical director of the anti-coagulation clinic may determine threshold for contacting the physician.

NWOCC ANTI-COAGULATION CLINIC DOSING ALGORITHM: INR 2.5 - 3.5 (Goal 3.0)

INR	ACTION
≤ 1.5	Increase weekly dose by 20%; repeat INR in 7-10 days, notify physician
1.51 - 2.49	Increase weekly dose by 15%; repeat INR in 7 - 10 days
2.50 - 3.50 *	No change. Re-check INR in 4 weeks. If last result abnormal, re-check in 2 weeks.
3.51 - 5.99	If INR 3.51 - 4.59 do not hold warfarin If high first time, decrease dose by 5%, second time decrease dose by 10% unless it goes to next range. Repeat INR in 7 days or less. Decrease dose. If INR 4.60 - 5.29 hold for 1 day. Decrease dose by 10%. If INR 5.30 - 5.99 hold for 2 days. Decrease dose by 10%.
6.00 - 8.99	Hold Coumadin for 2 days; repeat INR in 3 days. Restart at lower dose (decrease weekly dose by 15%) when INR therapeutic. Check INR weekly until stable. Consider Vitamin K 1 - 2.5 mg PO if at increased risk of bleeding. Inform physician.
≥ 9.0	Inform physician. Hold Coumadin per MD order. Consider Vitamin K 3 - 5 mg PO.
> 18 or if serious bleeding regardless of INR	Inform physician immediately. Send patient to Emergency Room.

* If INR between 3.50 - 3.70, consider no change in dose with repeat INR in 7 - 10 days.

The clinical director of the anti-coagulation clinic may determine threshold for contacting physician.