Protocol for switching to Rivaroxaban for existing patients with non-valvular atrial fibrillation (NVAF) on Edoxaban.

This resource has been developed to facilitate the safe and effective switch from edoxaban to rivaroxaban, using current accessible references and is correct at the time of approval. Clinicians using this resource must refer to local guidelines, use their own clinical judgement and take responsibility for their prescribing decisions.

Shropshire Telford and Wrekin ICB (STW ICB) Medicines Optimisation Team only have oversight for the management of errors occurring within their own organisation. Each organisation is therefore responsible for any prescribing errors or omissions that may occur within their organisation because of using this resource and must follow their own safety governance process.

Organisations must inform the STW ICB Medicines Optimisation team should they become aware of any errors or updates required within this document.

Author(s) name and post	Anita Sharma - Senior Pharmacist (PCN & Place Team)
Clinical Review by	Naz Khan – STW CVRM Clinical Lead
Version	1
Approval Date	11th August 2026
Revision Date	July 2028

With thanks and acknowledgement to Welsh Medicines Advice Service Team.

Table of Contents

1. Introduction

There are currently four direct oral anticoagulants (DOACs) available and licensed in the UK for stroke prevention in non-valvular atrial fibrillation (NVAF); apixaban, dabigatran, edoxaban, and rivaroxaban. Apixaban and rivaroxaban are now available as a generic preparation, making them the most cost-effective DOACs.This document gives guidance on switching from edoxaban to rivaroxaban tablets (both once daily DOACs).

2. Non-valvular atrial fibrillation

Non-valvular atrial fibrillation refers to atrial fibrillation in the **absence of a mechanical prosthetic heart valve or moderate-to-severe mitral stenosis** (usually of rheumatic origin), where the choice of oral anticoagulant could include either warfarin or a DOAC.

3. Comparative efficacy

Apixaban, dabigatran, edoxaban and rivaroxaban are all recommended by NICE as options for stroke prevention in eligible adults with NVAF. The choice of DOAC should reflect clinical suitability and patient preference.

4. Scope

The procedure supports prescribers and pharmacists to:

- switch patients aged 18 years and over established on edoxaban, to rivaroxaban tablets for stroke prevention in NVAF, where clinically appropriate as part of shared decision making.
- review the DOAC and dosing appropriateness prior to switching to ensure rivaroxaban is prescribed safely and only where appropriate.

This procedure does not include advice on switching patients from warfarin to rivaroxaban, this is outside of the scope of this procedure.
This procedure does not include advice on switching patients from apixaban or dabigatran to rivaroxaban, this is outside of the scope of this procedure. Changes should only be made AFTER consultation with the patient.

5. Patients EXCLUDED from Edoxaban to Rivaroxaban switch

Individuals should not be switched to rivaroxaban if:

- They do not provide consent.
- They are less than 18 years of age.
- They have an indication other than NVAF (see section 6).
- They would not be able to consistently take rivaroxaban with a meal as this can significantly affect absorption and subsequent drug levels. This should be considered carefully in elderly and frail patients.
- They require drug administration via NJ/PEJ/PEGJ tube, as rivaroxaban should not be administered distal to the stomach – see Summary of Product Characteristics (SmPC).
- They have a known hypersensitivity to rivaroxaban or any of the excipients.

- Their creatinine clearance is less than 15 mL/min, or they are undergoing dialysis (warfarin is recommended).
- No recent (within the last 6 months) recommended monitoring has occurred.
- They have a mechanical prosthetic heart valve or moderate-to-severe mitral stenosis.
- Recent or Complex Acute Coronary Syndrome (ACS): They have experienced an ACS presentation or coronary intervention within the last 12 months, or currently require specialist anticoagulation management (e.g., dual/triple antithrombotic therapy).
  Note: *While Rivaroxaban is strongly supported in this cohort by the PIONEER AF-PCI trial, any medication adjustments for these high-risk individuals must be directed solely by cardiology specialists.*
- They have hepatic disease associated with coagulopathy and clinically relevant bleeding risk, including cirrhosis classified as Child–Pugh B or C.
- They have antiphospholipid syndrome.
- They are pregnant or breastfeeding.
- They have uncontrolled severe hypertension (systolic BP ≥170 mmHg and/or diastolic BP ≥100 mmHg).
- They have a major bleeding risk (e.g., current or recent gastrointestinal ulcer; oesophageal varices; recent brain/ spinal injury; recent brain, spine, or ophthalmic surgery; recent intracranial haemorrhage; malignant neoplasm at high risk of bleeding; vascular aneurysm; active bleeding; arteriovenous malformations; major intraspinal or intracerebral vascular abnormalities).
- **They are taking the following medicines**:
  - another anticoagulant, except as part of an appropriate anticoagulant-switching process or under specialist supervision; or
  - a regularly prescribed NSAID that has not been clinically reviewed. Avoid long-term NSAID use where possible. If treatment must continue, use the lowest effective dose for the shortest duration, consider gastroprotection where appropriate, and monitor for anaemia or signs of bleeding.
- **Planned cardioversion or Catheter Ablation:** Planned cardioversion is not, by itself, a contraindication to rivaroxaban. Rivaroxaban may be initiated or continued in patients who require cardioversion. Where cardioversion or ablation is planned or imminent, confirm the anticoagulation plan with the responsible cardiology or anticoagulation team before switching. Confirm and document adherence to anticoagulant treatment, as missed doses may affect whether cardioversion can proceed. Please refer to the SmPC for Rivaroxaban for information on interactions, the full list of contraindications and cautions to consider when switching to rivaroxaban. Patient preference is also an important factor to consider.

6. Patients prescribed DOACs for multiple indications

There are several reasons why patients may be taking a DOAC either for a fixed period or for the long-term. All DOACs are licensed and approved by NICE for prevention of stroke in NVAF and for the treatment/prophylaxis of thrombosis (DVT/PE). Some DOACs are also used for thromboprophylaxis following joint replacement. This protocol is for **patients receiving a DOAC for stroke prevention in NVAF**. If a patient is on a long-term DOAC for another indication, this is outside of the scope of this protocol.

7. Switching to Rivaroxaban

- When individuals on edoxaban for NVAF present for a medication review, or DOAC monitoring is due, the prescriber should consider switching edoxaban to rivaroxaban tablets as part of shared decision making.
- A search can be run to identify suitable individuals (see Appendix 4):
    - adults aged 18 years and over who are currently receiving prescriptions for edoxaban and have NVAF with no valid exclusion criteria as outlined above (section 5).
    - A data collection form (Appendix 2) can be used to identify suitable patients. Use medical records to populate relevant information as per the data collection form.
- Refer to the SmPC for rivaroxaban tablets for detailed information of cautions and contraindications that may need to be considered before proceeding with the switch.
- Use a serum creatinine result from within the previous 6 months and an actual body-weight measurement from within the previous 6 months to calculate creatinine clearance (CrCl) using the Cockcroft–Gault equation. Obtain more recent results if the individual is clinically unstable or there is reason to believe that renal function or body weight has changed. Individuals without the recommended monitoring results must have a current actual body-weight, Urea & Electrolytes (U&Es) for creatinine, Liver Function Tests (LFTs), and a Full Blood Count (FBC) completed before a switch is considered.
- Individuals lacking recent data must have and a baseline blood panel—including Urea & Electrolytes (U&Es) for creatinine, Liver Function Tests (LFTs), and a Full Blood Count (FBC)—completed and reviewed before a switch is approved.
- Utilise the ORBIT bleeding risk score to identify and actively manage modifiable bleeding risk factors. Review and address modifiable bleeding risk factors, including uncontrolled hypertension, concurrent antiplatelets, SSRIs or NSAIDs, harmful alcohol consumption and reversible causes of anaemia.
  Note: *According to the ESC AF guidelines, a high or elevated bleeding risk score must never be used as a justification to withhold stroke prevention therapy or prevent a switch to rivaroxaban. Instead, a high-risk baseline should prompt proactive risk mitigation and consideration for more frequent clinical and renal monitoring intervals.*
- All consultations for changes must take place with direct patient contact. This may be via a face-to-face or telephone consultation. In addition, a leaflet should also be issued for patients suitable for

the switch in a format that is clear and accessible for the patient and/or their representative. This can be found in Appendix 3.

- Individuals should be advised to use up their supply of edoxaban before starting the newly prescribed rivaroxaban to prevent any wastage.
- After finishing their supply of edoxaban, start rivaroxaban tablets at the time the next dose of edoxaban would have been due.
- Add rivaroxaban tablets to repeat medications and remove edoxaban from repeats.
- Ensure repeat issues are only authorised until next blood test or as per practice protocol.
- Ensure ongoing review and recall dates are in place in accordance with the patient's original monitoring schedule and current Specialist Pharmacy Service guidance on DOAC monitoring.
- Practices may wish to consider contacting patients after the switch to check that patients are taking rivaroxaban correctly and not experiencing any problems.

7. Rivaroxaban dosing

The standard recommended dose for stroke prevention in non-valvular atrial fibrillation (NVAF) is **Rivaroxaban 20mg once daily**. However, the maintenance dose must be determined by the patient's calculated creatinine clearance (CrCl).

Calculated CrCl (mL/min)	Recommended Rivaroxaban Dose	Clinical Guidance & Monitoring
≥ 50 mL/min	20 mg once daily	Standard maintenance dose.
30–49 mL/min	15 mg once daily	**Reduced dose** for moderate renal impairment.
15–29 mL/min	15 mg once daily	**Use with caution**. Severe renal impairment. Enforce more frequent renal monitoring (CrCl / 10).
< 15 mL/min *(or on dialysis)*	Not recommended	**Contraindicated**. Avoid use and seek specialist cardiology/haematology advice.

Note: Important Administration Counselling - Clinicians must advise patients that Rivaroxaban 15mg and 20mg tablets **must always be taken with food (a main meal)** to ensure proper drug absorption and efficacy. Patients may need to change the time of day that they usually take their dose to ensure they can take it with a meal.

Calculating renal function

Use of the Cockcroft-Gault equation is recommended to calculate creatinine clearance (CrCl), as this equation accounts for body weight, accurately reflecting renal function. Cockcroft-Gault calculators can be accessed within the GP clinical system tools and on the MDcalc website.
https://www.mdcalc.com/calc/43/creatinine-clearance-cockcroft-gault-equation

The most up to date values for the patient's actual body weight and height will have to be inserted. It should be remembered that all values are estimates of renal function. Patient's actual bodyweight should be used in the calculation because actual body weight was used in the clinical trials.

EMIS CrCl calculator uses:

Actual body weight is used for CrCl calculation for patients taking apixaban, edoxaban or rivaroxaban. The single exception applies to obese patients taking Dabigatran, in this case the calculator uses ideal body weight. In these cases, you should record the CrCl for actual body weight in the consultation as the actual body weight was used in the clinical trials for AF with all DOACs. The calculator displays text indicating whether actual body weight or ideal body weight (IBW) has been used each time CrCl is calculated.

9. Body weight

Management of Extreme Obesity (Weight >120kg or BMI >40 kg/m²): In accordance with EHRA and ISTH guidelines, standard doses should be prescribed based on actual body weight. However, for individuals at extreme weight thresholds, consider the need for specialist anti-Xa monitoring (measuring peak and trough plasma levels) via haematology to verify therapeutic drug concentrations and ensure optimal anticoagulation safety. In patients over 150kg, prescribing of DOACs should be on a case-by-case basis and involve specialist input.

Rivaroxaban does not require dose adjustment in adults solely on the basis of body weight. However, clinical evidence is more limited at extremes of body weight. Individuals weighing less than 50 kg or more than 150 kg should not be switched routinely under this protocol without an individual clinical risk–benefit assessment and specialist advice. Any STW recommendation to prefer warfarin or apply specific weight thresholds must be agreed through the appropriate local cardiology or hematology governance processes.

10. Liver disease

Rivaroxaban is contraindicated in individuals with hepatic disease associated with coagulopathy and clinically relevant bleeding risk, including individuals with cirrhosis classified as Child–Pugh B or C. Do not switch these individuals to rivaroxaban. Where liver disease is known or suspected but its severity is unclear, seek specialist advice before switching.

11. Drug Interactions

Before switching, review all prescribed, over-the-counter and complementary medicines for potential interactions with rivaroxaban. Pay particular attention to other anticoagulants, medicines that may significantly increase or reduce rivaroxaban exposure, and medicines that increase bleeding risk, including antiplatelets, non-steroidal anti-inflammatory drugs (NSAIDs), selective serotonin reuptake inhibitors (SSRIs) and serotonin–noradrenaline reuptake inhibitors (SNRIs).

Where a clinically significant interaction is identified, do not proceed with the switch until the treatment has been reviewed and specialist advice obtained where necessary.

Consider the need for gastroprotection for patients with a high bleeding risk or requiring essential, short-course NSAID treatment. Risk factors that increase the risk of bleeding include a low body weight, renal impairment, low haemoglobin levels or a known history of gastrointestinal disease.

Refer to the current SmPC for Rivaroxaban and Specialist Pharmacy Service guidance on DOAC interactions for the full list of interactions and recommended management.

12. Patient education/discussion

Arrange a consultation to discuss anticoagulation options and establish whether the individual is suitable for a switch to rivaroxaban. When discussing the benefits and risks of anticoagulation, use clinical risk profiles and personal preferences to guide treatment choices. Practical considerations may include, but are not limited to, the ability to reliably take with food, and the use of NJ/PEJ/PEGJ tubes.
When discussing anticoagulation treatment options, advise the individual of the risks and benefits of the different DOACs. Explain that apixaban and rivaroxaban are both cost-effective generic DOAC options for the NHS. Where apixaban is not clinically suitable or twice-daily treatment cannot be reliably managed, rivaroxaban may be considered, provided it is clinically appropriate and the individual can take it once daily with a meal. The final choice should reflect clinical suitability, patient
preference and shared decision making.

If suitable to switch, advise the individual:

- rivaroxaban must be taken **once a day with a main meal.**
- to use up the supply of their existing DOAC before switching to the rivaroxaban.
- to switch to rivaroxaban the **day after** using up their existing DOAC supply.
- to update their DOAC alert card

Refer to Appendix 1 and Appendix 3 to aid discussion with the patient

13. Patient compliance

- Ensure the patient is aware that rivaroxaban needs to be taken **ONCE A DAY, WITH A MEAL**. If there are any concerns regarding compliance with taking with a meal, the patient should not be switched to rivaroxaban.
- There are no known issues with using rivaroxaban in compliance devices, however, repackaging medication outside of the manufacturers original packaging involves risks and is often unlicensed. The community pharmacist should be made aware of the change to avoid dispensing/supply error/duplication of script.
- The tablets can be swallowed whole or crushed and mixed with water or apple puree. If crushing the tablets, this should be done immediately before taking the dose. The crushed tablet may also be given through gastric tubes. This is a **licensed** use – see SmPC for details.

14. Monitoring requirements

Before switching

- Confirm that both the renal function and body weight have been checked within the previous 6 months. Obtain more recent results if the individual is clinically unstable or there is reason to believe that renal function or body weight has changed.
- Confirm that a recent full blood count, liver function tests and urea and electrolytes are available and that the results remain clinically appropriate.
- Calculate creatinine clearance using the Cockcroft–Gault equation. Do not use estimated glomerular filtration rate (eGFR) to determine the rivaroxaban dose.

After switching

- Arrange a DOAC review approximately one month after the switch. Confirm that edoxaban has been stopped, rivaroxaban has been started correctly and is being taken once daily with a meal. Review adherence, adverse effects, bleeding or thromboembolic symptoms, interacting medicines and the patient's DOAC alert card.

Ongoing monitoring

- Once treatment is stable, undertake a DOAC review at least annually. This should include full blood count, liver function tests, urea and electrolytes, serum creatinine with calculated creatinine clearance, and body weight.
- Consider more frequent monitoring:
    - approximately every four months in people aged over 75 years or who are frail
    - where CrCl is below 60 mL/min, using CrCl divided by 10 as a guide to the monitoring interval in months
    - following an intercurrent illness that may affect renal or hepatic function
    - where interacting medicines, hepatic deterioration, significant weight change or other clinical concerns are present.
- Review the rivaroxaban dose if renal function deteriorates or improves sufficiently to cross a dosing threshold. Rivaroxaban is not recommended if creatinine clearance falls below 15 mL/min.

15. Bibliography

1. Nottingham and Nottinghamshire Integrated Care Board Medicines Optimisation Team. Procedure for switching to rivaroxaban tablets for existing patients with non-valvular atrial fibrillation (NVAF) on edoxaban. Version 2.0. Approved July 2026; review date July 2028.
2. Welsh Medicines Advice Service. Resources to support switching to rivaroxaban or apixaban for individuals with non-valvular atrial fibrillation taking a different direct oral anticoagulant, including the rivaroxaban switching tool and patient information leaflet. Updated October 2024. Available at: healthcare-professional resources and patient information (accessed 2 August 2026).
3. National Institute for Health and Care Excellence. Atrial fibrillation: diagnosis and management. NICE guideline NG196. Published 27 April 2021; last updated 30 June 2021. Available at: www.nice.org.uk/guidance/ng196 (accessed 2 August 2026).
4. National Institute for Health and Care Excellence. Rivaroxaban for the prevention of stroke and systemic embolism in people with atrial fibrillation. Technology appraisal guidance TA256. Published 23 May 2012; last updated 2 July 2021. Available at: www.nice.org.uk/guidance/ta256 (accessed 2 August 2026).
5. National Institute for Health and Care Excellence. Edoxaban for preventing stroke and systemic embolism in people with non-valvular atrial fibrillation. Technology appraisal guidance TA355. Published 23 September 2015; last updated 2 July 2021. Available at: www.nice.org.uk/guidance/ta355 (accessed 2 August 2026).
6. Amarox Limited. Rivaroxaban 15 mg and 20 mg film-coated tablets: Summaries of Product Characteristics. Electronic Medicines Compendium; last updated 13 March 2026. Available at: 15 mg SmPC and 20 mg SmPC (accessed 2 August 2026).
7. Daiichi Sankyo UK Limited. Lixiana 15 mg, 30 mg and 60 mg film-coated tablets: Summary of Product Characteristics. Electronic Medicines Compendium; last updated 26 September 2025. Available at: www.medicines.org.uk/emc/product/6905/smpc (accessed 2 August 2026).
8. Specialist Pharmacy Service. DOACs (Direct Oral Anticoagulants) monitoring. Published 5 July 2021; last updated 3 September 2025. Available at: sps.nhs.uk/monitorings/doacs-direct-oral-anticoagulants-monitoring (accessed 2 August 2026).
9. Nottinghamshire Area Prescribing Committee. Anticoagulants in atrial fibrillation: prescriber decision support on anticoagulation. Version 1.3. Last reviewed May 2025; review date May 2028. Available at: www.nottsapc.nhs.uk/media/vlsfl14j/anticoagulants-in-af.pdf (accessed 2 August 2026).
10. Steffel J, Collins R, Antz M, et al. 2021 European Heart Rhythm Association Practical Guide on the use of non-vitamin K antagonist oral anticoagulants in patients with atrial fibrillation. Europace. 2021;23(10):1612-1676. doi:10.1093/europace/euab065.
11. Cockcroft DW, Gault MH. Prediction of creatinine clearance from serum creatinine. Nephron.1976;16(1):31-41. doi:10.1159/000180580.
12. MDCalc. Creatinine Clearance (Cockcroft-Gault Equation) calculator. Available at: www.mdcalc.com/calc/43/creatinine-clearance-cockcroft-gault-equation (accessed 2 August 2026).
13. Martin KA, Beyer-Westendorf J, Davidson BL, et al. Use of direct oral anticoagulants in patients with obesity for treatment and prevention of venous thromboembolism: Updated communication from the ISTH SSC Subcommittee on Control of Anticoagulation. *J Thromb Haemost*. 2021;19(8):1874-1882. doi:10.1111/jth.15358. Available at: Wiley Online Library (accessed 2 August 2026).
14. Van Gelder IC, Rienstra M, Bunting KV, et al. 2024 ESC Guidelines for the management of atrial fibrillation developed in collaboration with the European Association for Cardio-Thoracic Surgery (EACTS). *Eur Heart J*. 2024;45(36):3314–3414. doi:10.1093/eurheartj/ehae177. Available at: European Heart Journal (accessed 2 August 2026).

Appendix 1 – Rivaroxaban switch algorithm

Switching from Edoxaban to Rivaroxaban in adult patients with non-valvular AF

This tool does not replicate complete source information or consider all individual patient circumstances. Avoid using it for the sole basis of decisions or a substitute for a clinical conversation with a healthcare professional. Consult rivaroxaban summary of product characteristics (SmPC) before prescribing. https://www.medicines.org.uk/emc

Do not switch using this algorithm if:

- any exclusion in section 5 applies.
  or
- any issue requiring further assessment remains unresolved. Seek specialist advice where required.

Counselling points

- Start the first rivaroxaban dose when the next dose of edoxaban would have been due.
- Take rivaroxaban once daily with a meal.
- Do not take edoxaban and rivaroxaban together.
- Supply the patient information leaflet, counsel the individual and update the DOAC alert card.

Switching from edoxaban to rivaroxaban

REVIEW individuals with NVAF

Complete the pre-switch review in sections 5, 7 and 14. Confirm eligibility, exclusions, ORBIT bleeding risk and medicine interactions. Confirm that FBC, LFTs, U&Es, serum creatinine and body weight have been recorded within the previous six months and remain clinically appropriate. Calculate creatinine clearance using the Cockcroft–Gault equation. Obtain more recent results where clinically indicated. Do not switch if creatinine clearance is below 15 mL/min or the individual is undergoing dialysis.

Does the individual have: CrCl <15ml/min or are they undergoing dialysis?

Yes → **Do not switch under this protocol**
Rivaroxaban is not recommended

No

Does the individual have: CrCl 15-49 ml/min

Yes → **Reduced Dosing**
Rivaroxaban 15mg **once** daily.
Use with caution if CrCl is 15–29 mL/min.

No

Normal Dosing

CrCl 50 mL/min or above
Rivaroxaban 20 mg once daily

Appendix 2 – Data collection form

Patient ID	Age (18 years or over)	Current Edoxaban dose	Diagnosis of NVAF and no other DOAC indication (Y/N)	Serum creatinine in last 6 months	Weight in last 6 months	Creatinine Clearance	Proposed rivaroxaban dose	C/I or exclusion to rivaroxaban switch? (Y/N)	Switch agreed (Y/N)

Appendix 3 – Patient Information Leaflet

Important Changes to your medication: Edoxaban

Switching to Rivaroxaban

Information for patients

You have received this leaflet because you are taking a blood thinning medicine, Edoxaban (Lixiana ®). Rivaroxaban is another blood thinning medicine. It is as effective as the other blood thinning medicines. Until recently, only one manufacturer made rivaroxaban. As it is no longer covered by a patent, rivaroxaban is now available from other manufacturers. This drives the price of rivaroxaban down, making it more cost effective for the NHS.

Soon, you will receive prescriptions for rivaroxaban **instead of** Edoxaban; **the two medications must not be taken together.**

How the switch will happen

Your GP practice will discuss with you about switching to rivaroxaban and provide more information.

How to take rivaroxaban

- Use up your current supply of edoxaban **before** starting the rivaroxaban.
- Start the rivaroxaban the day after you finish your edoxaban.
- Take your first dose of rivaroxaban at the time you would normally take the next dose of edoxaban. **Please note that it is very important that you take rivaroxaban with a main meal, so this might mean that you need to change the time of day that you take it.**
- Take the rivaroxaban **once a day, with a meal.**
- If you find the tablets hard to swallow, they may be crushed and mixed with water or apple puree immediately before taking them. Take the mixture straight away and then eat a meal immediately afterwards.

If you forget to take rivaroxaban

If you forget a dose, take it as soon as you remember on the same day, with a meal. Continue with your usual once-daily dose on the following day. Do not take more than one dose on the same day to make up for a missed dose. If you do not remember until the following day, skip the missed dose. If you have missed more than one dose or are unsure what to do, ask your doctor, pharmacist or nurse.

If you take too much rivaroxaban

You may be at risk of bleeding if you take more rivaroxaban than you have been prescribed. Contact NHS 111 or tell your doctor, pharmacist, or nurse immediately.

Further Information

Always read the patient leaflet that comes with your medicine and remember to always carry your alert card with you. If you have any questions about this change in medicine or would like to discuss it further, please speak to your GP or practice pharmacist, or your local community pharmacist.

Appendix 4 – Clinical Systems Resources

STW EMIS Web practices

A locally developed EMIS Web search has been built by the STW Medicines Optimisation Team to identify adult patients currently prescribed edoxaban for review under this protocol.

You will find the search on the following folder file path:

Enterprise Population reporting

STW Meds Optimisation

Enterprise > STW Meds Optimisation > Practice Level Searches > MQCF 26-27 > Project Switches

The search is a case-finding resource only. All patients identified must receive an individual clinical consultation and assessment in accordance with this protocol before any change in treatment is made. Inclusion in the search output does not confirm that a patient is suitable for switching.

Practices should use the approved STW search and should not amend the agreed search criteria without discussion with the STW Medicines Optimisation Team.

Disclaimer

This resource has been developed using currently available references to support the safe and effective switch from edoxaban to rivaroxaban. It reflects the evidence available at the time of approval.

The accuracy of the search output depends on complete and current clinical coding and prescribing records. Clinicians using this resource must refer to local guidelines, use their own clinical judgement and take responsibility for their prescribing decisions. Consult the current rivaroxaban Summary of Product Characteristics before prescribing.