South East London Guidance for Prescribing Enoxaparin (Inhixa®)

This document summarises the local guidance for the safe prescribing of enoxaparin in primary care. It is aimed at all health care professionals involved in the prescribing, dispensing or administration of enoxaparin for patients in South East London.

All Acute Trusts in South East London now have enoxaparin (Inhixa®) as the low-molecular weight heparin (LMWH) therapy of choice.

Key messages

Enoxaparin is a biological medicine and as biosimilars are now available and to avoid inadvertent switching, it should be prescribed by brand name Inhixa®.

All new patients will be started on Inhixa® and trained to use this device.

All existing patients should continue with Clexane®, the brand they were initiated on. If the patient is to be switched to Inhixa®, this will be done by the specialist and the patient will be trained to use the device.

Patients on long term Dalteparin (Fragmin®), will be switched to Inhixa® if suitable. This will be done by the specialist and the patient will be trained to use the device.

Request to Transfer Prescribing Responsibility to Primary Care for Patients on Enoxaparin.

• The only LMWH approved for transfer of prescribing responsibility to primary care in South East London is enoxaparin. For all other LMWHs, prescribing remains the responsibility of the initiating clinician / clinical team / organisation.

• Primary care should only be requested to prescribe enoxaparin for the indications in Table 1 overleaf.

• GPs should never be asked to initiate enoxaparin treatment in primary care.

Key Safety Considerations when Prescribing Enoxparin in Primary Care

• Before agreeing to take on prescribing, the primary care clinician should ensure that they are confident of the diagnosis, dose, intended duration and monitoring of enoxaparin therapy.

• Essential information, including dose, bodyweight, renal function, indication and duration of treatment, must be communicated at the point of transfer of care.

• Dosing should be based on a recent accurate bodyweight which will be reviewed by the specialist team.

• Dosing should be based on up to date prescribing information from the British National Formulary (BNF) or Summary of Prescribing Characteristics (SPC) for enoxaparin. If there are concerns regarding the dose, the primary care clinician should confirm with the initiating clinician.

• Dosing frequency often depends on indication – please check carefully whether the patient is prescribed once or twice daily doses.

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• The intended duration of therapy will be clearly documented in the patient notes and discharge summary – a STOP date should be added to the repeat prescription if intended for a course.

• In some circumstances, enoxaparin will be used outside of the licensed indication, such as in high risk pregnancy. Informed consent should be obtained and documented.

• Complex patients including paediatrics, patients with severe renal dysfunction (calculated creatinine clearance (CrCl) <30ml/min), very underweight (<50kg) or severe obesity (>150kg), patients with severe hepatic impairment and those known to be at an increased risk of bleeding may require monitoring of factor Xa levels and are therefore not suitable for transfer to primary care.

Monitoring of enoxaparin

• Careful re-assessment of the risk / benefit of continued enoxaparin therapy should be undertaken regularly

• Baseline full blood count (including platelets) and urea and electrolytes (U& Es) should be measured and CrCl calculated using the Cockcroft-Gault equation on transfer of care and at regular intervals throughout therapy.

• Thrombocytopenia, if it occurs, usually appears between the 5th and 21st day of treatment, which is in part the reason for prescribing transfer at 3 or 6 months. If platelet count drops below 30% of baseline – contact haematology for advice.

• Hyperkalaemia may occur with the risk increasing with longer durations of therapy

• If severe renal dysfunction occurs during therapy (calculated CrCl <30ml/min) - contact haematology for advice.

Administration of enoxaparin therapy

•Enoxaparin is usually administered by the patient or carer following training by the initiating team / organisation.

•A video demonstrating administration of Inhixa® can found at: https://www.techdow-pharma.co.uk/videoplay.html

Note: Referrals to district nursing for administration of enoxaparin should follow local processes, when treatment is stopped, this should be communicated clearly to the district nursing team/ service.

Table 1: Enoxaparin Prescribing Responsibilities

Subspecialty	Indication	Duration	Initiated by	Prescribed by	Monitored by
Anticoagulation	Patients requiring anticoagulation but unable to take oral anticoagulant therapies (e.g. mechanical valve in situ, AF, DVT/PE treatment or prevention)	For duration of indication I.e. Valve/AF: indefinite; DVT/PE 3-6 months or long term if ongoing risk of recurrence	Hospital/ anticoagulant and thrombosis team	**Amber 2 for primary care:** considered for transfer to of prescribing responsibility to primary care after 3 months of treatment	Hospital/anticoagulant and thrombosis team or GP following transfer of care
Oncology	Treatment and secondary prevention of DVT/PE in patients with cancer. DOAC are usually used first line in cancer-related VTE now but LMWH used for patients who are unsuitable. LMWH may also be given in place of warfarin for patients undergoing chemotherapy due to potential interactions with warfarin.	Usually at least 6 months for DVT/PE. Extended duration as advised by specialist	Oncology/thrombosis team	**Amber 2 for primary care:** Transfer of prescribing responsibility to primary care after six months when the need for a longer duration of LMWH has been established	Hospital oncology team or GP following transfer of care
General medicine/ Anticoagulation	Suspected or confirmed DVT/PE initiation of treatment. For when INR is subtherapeutic and interim treatment is required (bridging), or where a DVT /PE is suspected but not yet confirmed.	Until target INR is achieved on warfarin OR initiation of a DOAC *or* until a diagnosis of DVT/PE is excluded	Hospital/ anticoagulant and thrombosis team	Hospital/anticoagulant team **Red**	Hospital/anticoagulant and thrombosis team
Emergency department / fracture clinic	Thromboprophylaxis in lower limb immobilisation with risk factors	Until mobile and risk has reduced	Hospital/orthopaedics team	Hospital/orthopaedics team **Red**	Hospital/orthopaedics team
Pregnancy	Treatment of DVT / PE in pregnancy. Patients requiring anticoagulation (e.g. mechanical valve in situ) but unable to have warfarin or DOAC due to pregnancy	Until onset of labour and then on advice of specialist if to continue after birth	Obstetric specialist only	Obstetric specialist / haematology only **Red**	Obstetric specialist / haematology only

Pregnancy	All pregnancies requiring thromboprophylaxis	Until onset of labour and then on advice of specialist if to continue after birth	Obstetric specialist only	Obstetric specialist / haematology only **Red**	Obstetric specialist / haematology only
Pregnancy	Postnatal thromboprophylaxis depending on risk factors	For 10 days or six weeks depending on risk factors	Obstetric specialist only	Obstetric specialist / haematology only **Red**	Obstetric specialist / haematology only
High risk surgery	Extended thromboprophylaxis depending on risk factors, for example: major cancer surgery in abdomen or pelvis, resection for IBD, hip fracture surgery, bariatric surgery or persistent immobility.	For up to 6 weeks post procedure	Hospital surgical team	Hospital surgical team **Red**	Hospital surgical team
Surgery	Bridging of anticoagulant therapy pre-surgery	For up to 5 days pre-surgical procedure	Hospital surgical team or anticoagulant team	Hospital surgical team or anticoagulant team **Red**	Not required

Abbreviations: AF: atrial fibrillation; DOAC: direct-acting oral anticoagulant; DVT: deep vein thrombosis; IBD: inflammatory bowel disease; INR: international normalised ratio; LMWH: low-molecular weight heparin; PE: pulmonary embolism; VTE: venous thromboembolism