



# Xarelto<sup>®</sup> (rivaroxaban) Prescriber Guide

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The Prescriber Guide is in line with the conditions of the marketing authorisation.

Please refer to SmPCs for full prescribing information.



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## Prescriber Guide

The Prescriber Guide provides recommendations for the use of Xarelto in order to minimise the risk of bleeding during treatment with Xarelto.

The Prescriber Guide does not substitute the Xarelto Summary of Product Characteristics (SmPC).\*

[\*optional: <https://www.ema.europa.eu/en/medicines/human/EPAR/xarelto>]

## Patient Alert Card

A Patient Alert Card must be provided to each patient who is prescribed Xarelto 2.5 mg, 10 mg, 15 mg or 20 mg tablets or Xarelto 1 mg/ml granules for oral suspension, and is provided with the product package. The implications of anticoagulant treatment should be explained. Specifically, the need for compliance, signs of bleeding and when to seek medical attention should be discussed with the patient.

The Patient Alert Card will inform physicians and dentists about the patient's anticoagulation treatment and will contain emergency contact information. The patient should be instructed to carry the Patient Alert Card at all times and present it to every healthcare provider.

For Xarelto 1 mg/ml granules for oral suspension for use in children, please take note of the QR code on the respective Patient Alert Card, which leads to an educational video showing how to prepare and administer the oral suspension.

## Dosing recommendations

### Stroke prevention in adult patients with non-valvular atrial fibrillation

The recommended dose for prevention of stroke and systemic embolism in patients with non-valvular atrial fibrillation (SPAF) is 20 mg once daily.

#### DOSING SCHEME

##### Continuous treatment



Xarelto 20 mg once daily\*

Take with food

\* For the recommended dosing scheme for patients with atrial fibrillation and moderate or severe renal impairment, see below.

### Patients with renal impairment

In patients with moderate (creatinine clearance [CrCl] 30–49 ml/min) or severe (CrCl 15–29 ml/min) renal impairment, the recommended dose is 15 mg once daily. Xarelto is to be used with caution in patients with severe renal impairment (CrCl 15–29 ml/min) and is not recommended in patients with CrCl <15 ml/min.

Xarelto should be used with caution in patients with renal impairment concomitantly receiving other medicinal products that increase rivaroxaban plasma concentrations.

### Duration of therapy

Xarelto should be continued long term provided the benefit of stroke prevention therapy outweighs the potential risk of bleeding.

### Missed dose

If a dose is missed, the patient should take Xarelto immediately and continue on the following day with the once-daily intake as recommended. The dose should not be doubled within the same day to make up for a missed dose.

### Patients with non-valvular atrial fibrillation undergoing PCI with stent placement

There is limited experience of a reduced dose of 15 mg Xarelto once daily (or 10 mg Xarelto once daily for patients with moderate renal impairment [CrCl 30–49 ml/min]) in addition to a P2Y<sub>12</sub> inhibitor for a maximum of 12 months in patients with non-valvular atrial fibrillation who require oral anticoagulation and undergo PCI with stent placement.

### Patients undergoing cardioversion

Xarelto can be initiated or continued in patients who may require cardioversion.

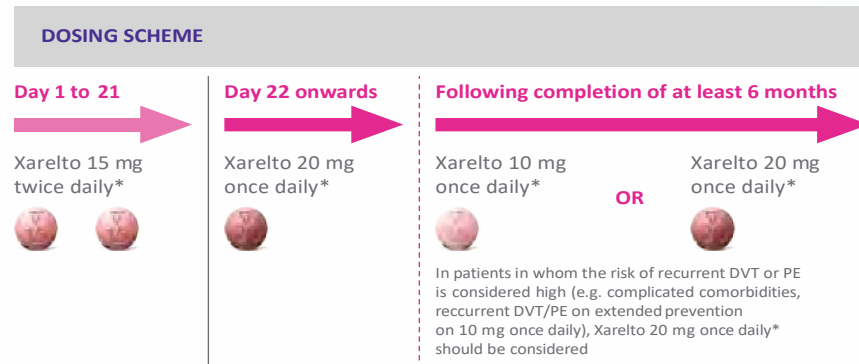
For transoesophageal echocardiogram (TEE) guided cardioversion in patients not previously treated with anticoagulants, Xarelto treatment should be started at least 4 hours before cardioversion to ensure adequate anticoagulation. For all patients, confirmation should be sought prior to cardioversion that the patient has taken Xarelto as prescribed. Decisions on initiation and duration of treatment should take established guideline recommendations for anticoagulant treatment in patients undergoing cardioversion into account.

## Treatment of deep vein thrombosis (DVT) and pulmonary embolism (PE), and prevention of recurrent DVT and PE in adult patients and in children

### Adults

Adult patients are initially treated with Xarelto 15 mg **twice daily** for the first 3 weeks. This initial treatment is followed by Xarelto 20 mg **once daily** for the continued treatment period. When extended prevention of recurrent DVT and PE is indicated (following completion of at least 6 months' therapy for DVT or PE), the recommended dose is 10 mg **once daily**. In patients in whom the risk of recurrent DVT or PE is considered high, such as those with complicated comorbidities, or who have developed recurrent DVT or PE on extended prevention with Xarelto 10 mg **once daily**, a dose of Xarelto 20 mg **once daily** should be considered.

Xarelto 10 mg is **not** recommended for the initial 6 months' treatment of DVT or PE.



**Xarelto 10 mg: TAKE WITH OR WITHOUT FOOD – Xarelto 15/20 mg: MUST BE TAKEN WITH FOOD**

\* For the recommended dosing scheme for patients with DVT/PE and moderate or severe renal impairment, see next page.

### Children

In paediatric patients 6 months to <18 years of age, Xarelto treatment using the most appropriate formulation should be initiated following  $\geq 5$  days of initial anticoagulation treatment with parenteral heparins. Dosing is based on body weight.

In paediatric patients from term neonates to <6 months of age, who at birth had  $\geq 37$  weeks of gestation, weigh  $\geq 2.6$  kg, and have had  $\geq 10$  days of oral feeding, Xarelto treatment using the oral suspension formulation should be initiated following  $\geq 5$  days of initial anticoagulation treatment with parenteral heparins. Dosing is based on body weight.

For children and adolescents weighing  $\geq 30$  kg, Xarelto tablet (15 mg in children 30–<50 kg, 20 mg in children  $\geq 50$  kg) or oral suspension once daily can be administered. The dose is determined based on body weight.

For children and adolescents with body weight of 2.6 kg to <30.0 kg, only the oral suspension should be used. The dose and frequency of administration is determined based on body weight.

If the oral suspension is prescribed, the patient or caregiver should be advised to carefully read and follow the Instructions for Use (IFU) provided in the box of Xarelto granules for oral suspension. The IFU shows how to prepare and take or give Xarelto oral suspension.

It is recommended to advise the patient or caregiver which blue syringe (Liquid Dosing Device) to use to ensure that the correct volume is administered.

If the oral suspension is prescribed, the prescriber should remind the patient or caregiver of the individual weight-adjusted dose volume and frequency. Upon dispensation of the medication to the patient or caregiver, the dispensing healthcare provider (e.g. the pharmacist) should write the prescribed dose on the outer carton of the box.

**Body-weight-adjusted Xarelto dosing schedule for children from birth to less than 18 years of age in ml of suspension and mg of tablets**

Pharmaceutical form	Body weight [kg]		Regimen [mg] (1 mg=1 ml suspension)			Total daily dose [mg] (1 mg=1 ml)
	Min	Max	OD once a day	BID 2 times a day	TID 3 times a day	
Oral suspension	2.6	<3			0.8 mg	2.4 mg
	3	<4			0.9 mg	2.7 mg
	4	<5			1.4 mg	4.2 mg
	5	<7			1.6 mg	4.8 mg
	7	<8			1.8 mg	5.4 mg
	8	<9			2.4 mg	7.2 mg
	9	<10			2.8 mg	8.4 mg
	10	<12			3.0 mg	9.0 mg
	12	<30		5 mg		10 mg
Tablets or oral suspension	30	<50	15 mg			15 mg
	≥50		20 mg			20 mg

The weight of a child should be monitored and the dose reviewed regularly, especially for children <12 kg. This is to ensure a therapeutic dose is maintained.

Use is not recommended in children <6 months of age who:

- At birth had <37 weeks of gestation, or
- Have a body weight of <2.6 kg, or
- Had <10 days of oral feeding

as dosing of Xarelto cannot be reliably determined in these patient populations and was not studied.

## Patients with renal impairment

### Adults

Patients with moderate (CrCl 30–49 ml/min) or severe (CrCl 15–29 ml/min) renal impairment treated for acute DVT, acute PE and prevention of recurrent DVT and PE should be treated with Xarelto 15 mg twice daily for the first 3 weeks.

Thereafter, the recommended dose is Xarelto 20 mg once daily. A reduction of the dose from 20 mg once daily to 15 mg once daily should be considered if the patient's assessed risk of bleeding outweighs the risk of recurrent DVT and PE. The recommendation for the use of 15 mg is based on pharmacokinetic (PK) modelling and has not been studied in this clinical setting. Xarelto is to be used with caution in patients with severe renal impairment (CrCl 15–29 ml/min) and is not recommended in patients with CrCl <15 ml/min. When the recommended dose is 10 mg once daily (after ≥6 months of therapy), no dose adjustment from the recommended dose is necessary.

Xarelto should be used with caution in patients with renal impairment\* concomitantly receiving other medicinal products that increase rivaroxaban plasma concentrations.

### Children

No dose adjustment is required for children aged ≥1 year with mild renal impairment (glomerular filtration rate: 50 ml–80 ml/min/1.73 m<sup>2</sup>), based on data in adults and limited data in paediatric patients.

Xarelto is not recommended in children aged ≥1 year with moderate or severe renal impairment (glomerular filtration rate <50 ml/min/1.73 m<sup>2</sup>), as no clinical data is available.

In children aged <1 year, estimation of serum creatinine instead of GFR is applied. Xarelto is not recommended in children aged <1 year with serum creatinine results above 97.5<sup>th</sup> percentile, as no clinical data is available (see SmPC Granules for oral suspension for reference values).

\* With moderate renal impairment (CrCl 30–49 ml/min) for Xarelto 10 mg.

## Duration of therapy

### Adults

Short duration of therapy ( $\geq 3$  months) should be considered in patients with DVT/PE provoked by major transient risk factors (i.e. recent major surgery or trauma). Longer duration of therapy should be considered in patients with provoked DVT/PE not related to major transient risk factors, unprovoked DVT/PE, or a history of recurrent DVT/PE.

### Children

#### All children, except those aged <2 years with catheter-related thrombosis

Therapy with Xarelto should be continued for at least 3 months. Treatment can be extended up to 12 months when clinically necessary. The benefit-risk of continued therapy after 3 months should be assessed on an individual basis, taking into account the risk for recurrent thrombosis versus the potential bleeding risk.

#### Children aged <2 years with catheter-related thrombosis

Therapy with Xarelto should be continued for at least 1 month. Treatment can be extended up to 3 months when clinically necessary. The benefit-risk of continued therapy after 1 month should be assessed on an individual basis, taking into account the risk for recurrent thrombosis versus the potential bleeding risk.

## Missed dose

### Adults

#### **Twice-daily treatment period (15 mg twice daily for the first 3 weeks)**

If a dose is missed, the patient should take Xarelto immediately to ensure intake of 30 mg Xarelto per day. In this case, two 15 mg tablets may be taken at once. Continue with the regular 15 mg twice-daily intake on the following day.

#### **Once-daily treatment period (beyond 3 weeks)**

If a dose is missed, the patient should take Xarelto immediately and continue on the following day with the once-daily intake as recommended. The dose should not be doubled within the same day to make up for a missed dose.

### Children

#### **Once daily regimen**

A missed dose should be taken as soon as possible after it is noticed, but only on the same day. If this is not possible, the patient should skip the dose and continue with the next dose as prescribed. The patient should not take two doses to make up for a missed dose.

#### **Two times daily regimen**

A missed morning dose should be taken immediately when it is noticed, and it may be taken together with the evening dose. A missed evening dose can only be taken during the same evening.

#### **Three times daily regimen**

The three times daily administration schedule with approximately 8-hour intervals should be resumed at the next scheduled dose without compensating for the missed dose.

**On the following day**, the child should continue with the regular once, twice, or three times daily regimen.

## Prevention of atherothrombotic events in adult patients with coronary artery disease (CAD) or symptomatic peripheral artery disease (PAD) at high risk of ischaemic events

### DOSING SCHEME

#### Individual treatment duration



Xarelto 2.5 mg twice daily



Xarelto 2.5 mg: TAKE WITH OR WITHOUT FOOD

### Patients taking Xarelto 2.5 mg twice daily should also take a daily dose of 75–100 mg acetylsalicylic acid (ASA).

Safety and efficacy of Xarelto 2.5 mg twice daily in combination with ASA plus clopidogrel/ticlopidine has only been studied in patients with recent ACS (see below).

Dual antiplatelet therapy has not been studied in combination with Xarelto 2.5 mg twice daily in patients with CAD and/or PAD.

### Patients with renal impairment

No dose adjustment is required in patients with moderate renal impairment (CrCl 30–49 ml/min). Xarelto is to be used with caution in patients with severe renal impairment (CrCl 15–29 ml/min) and is not recommended in patients with CrCl <15 ml/min.

In patients with moderate renal impairment (CrCl 30–49 ml/min) concomitantly receiving other medicinal products that increase rivaroxaban plasma concentrations, Xarelto is to be used with caution.

### Duration of therapy

Duration of treatment should be determined for each individual patient based on regular evaluations and should consider the risk for thrombotic events versus the bleeding risks.

## Other warnings and precautions in CAD/PAD patients

In patients with an acute thrombotic event or vascular procedure and a need for dual antiplatelet therapy, the continuation of Xarelto 2.5 mg twice daily should be evaluated depending on the type of event or procedure and antiplatelet regimen.

Concomitant treatment of CAD/PAD with Xarelto 2.5 mg twice daily and ASA is contraindicated in patients with previous haemorrhagic or lacunar stroke, or any stroke within a month.

Xarelto co-administered with ASA should be used with caution in CAD/PAD patients:

- $\geq 75$  years of age. The benefit-risk of the treatment should be individually assessed on a regular basis
- With a lower weight (<60 kg)
- In CAD patients with severe symptomatic heart failure. Study data indicate that such patients may benefit less from treatment with Xarelto. (See section 5.1 of the SmPC for further clarification.)

### Xarelto missed dose

If a dose is missed, the patient should continue with the regular 2.5 mg Xarelto dose as recommended at the next scheduled time. The dose should not be doubled to make up for a missed dose.



## Prevention of atherothrombotic events in adult patients after an acute coronary syndrome (ACS) with elevated cardiac biomarkers

### DOSING SCHEME

#### Individual treatment duration



Xarelto 2.5 mg twice daily

 Xarelto 2.5 mg: TAKE WITH OR WITHOUT FOOD

The recommended dose of Xarelto is 2.5 mg twice daily, starting as soon as possible after stabilisation of the index ACS event but at the earliest 24 hours after hospital admission and at the time when parenteral anticoagulation therapy would normally be discontinued.

**In addition to Xarelto 2.5 mg, patients should also take a daily dose of 75–100 mg acetylsalicylic acid (ASA) or a daily dose of 75–100 mg ASA in addition to either a daily dose of 75 mg clopidogrel or a standard daily dose of ticlopidine.**

Treatment in combination with other antiplatelet agents, e.g. prasugrel or ticagrelor, has not been studied and is not recommended.

### Patients with renal impairment

No dose adjustment is required in patients with moderate renal impairment (CrCl 30–49 ml/min). Xarelto is to be used with caution in patients with severe renal impairment (CrCl 15–29 ml/min) and is not recommended in patients with CrCl <15 ml/min.

In patients with moderate renal impairment (CrCl 30–49 ml/min) concomitantly receiving other medicinal products that increase rivaroxaban plasma concentrations, Xarelto is to be used with caution.

### Duration of therapy

Treatment should be regularly evaluated in the individual patient, weighing the risk of ischaemic events against the bleeding risks. Extension of treatment beyond 12 months should be done on an individual patient basis as experience up to 24 months is limited.

### Other warnings and precautions in ACS patients

Xarelto, co-administered with ASA or with ASA plus clopidogrel or ticlopidine, should be used with caution in ACS patients:

- ≥75 years of age. The benefit risk of the treatment should be individually assessed on a regular basis
- With a lower weight (<60 kg)

Concomitant treatment of ACS with Xarelto and antiplatelet therapy is contraindicated in patients with a prior stroke or a transient ischaemic attack (TIA).

### Missed dose

If a dose is missed, the patient should continue with the regular 2.5 mg Xarelto dose as recommended at the next scheduled time. The dose should not be doubled to make up for a missed dose.

## Prevention of VTE in adult patients undergoing elective hip or knee replacement surgery

The recommended dose is 10 mg Xarelto taken orally once daily. The initial dose should be taken 6 to 10 hours after surgery, provided that haemostasis has been established.

### Duration of treatment

The duration of treatment depends on the individual risk of the patient for venous thromboembolism, which is determined by the type of orthopaedic surgery.

- For patients undergoing major hip surgery, a treatment duration of 5 weeks is recommended
- For patients undergoing major knee surgery, a treatment duration of 2 weeks is recommended

### Missed dose

If a dose is missed, the patient should take Xarelto immediately and then continue the following day with once-daily intake as before.

## Oral intake

Xarelto 2.5 mg and 10 mg tablets can be taken with or without food.

**Xarelto 1 mg/ml granules for oral suspension and Xarelto 15 mg and 20 mg tablets are to be taken with food.** The intake of these doses with food at the same time supports the required absorption of the drug, thus ensuring a high oral bioavailability.

### Adults

For patients who are unable to swallow whole tablets, a Xarelto tablet may be crushed and mixed with water or apple puree immediately prior to use and then administered orally. After the administration of crushed Xarelto 15 mg or 20 mg film-coated tablets, the dose should be immediately followed by food.

The crushed Xarelto tablet may also be given through gastric tubes after confirmation of the correct gastric placement of the tube. The crushed tablet should be administered in a small amount of water via a gastric tube, after which it should be flushed with water. After the administration of crushed Xarelto 15 mg or 20 mg film-coated tablets, the dose should then be immediately followed by enteral feeding.

### Children

For children weighing  $\geq 30$  kg who are unable to swallow whole tablets, Xarelto granules for oral suspension should be used. If the oral suspension is not immediately available, when doses of Xarelto 15 mg or 20 mg are prescribed, these could be provided by crushing the 15 mg or 20 mg tablet and mixing it with water or apple purée immediately prior to use and administered orally.

The oral suspension and the crushed Xarelto tablet may be given through nasogastric or gastric feeding tube. Gastric placement of the tube should be confirmed before administering Xarelto. Avoid administration of Xarelto distal to the stomach.

## Perioperative management

If an invasive procedure or surgical intervention is required, if possible and based on the clinical judgement of the physician:

- Xarelto 10/15/20 mg and Xarelto 1 mg/ml granules for oral suspension should be stopped at least 24 hours before the intervention
- Xarelto 2.5 mg should be stopped at least 12 hours before the intervention

If the procedure cannot be delayed, the increased risk of bleeding should be assessed against the urgency of the intervention.

Xarelto should be restarted after the invasive procedure or surgical intervention as soon as possible provided the clinical situation allows, and adequate haemostasis has been established.

## Spinal/epidural anaesthesia or puncture

When neuraxial anaesthesia (spinal/epidural anaesthesia) or spinal/epidural puncture is employed, patients treated with antithrombotic agents for prevention of thromboembolic complications are at risk of developing an epidural or spinal haematoma, which can result in long-term or permanent paralysis. The risk of these events may be increased by the post-operative use of indwelling epidural catheters or the concomitant use of medicinal products affecting haemostasis. The risk may also be increased by traumatic or repeated epidural or spinal puncture. Patients are to be frequently monitored for signs and symptoms of neurological impairment (e.g. numbness or weakness of the legs, bowel or bladder dysfunction). If neurological compromise is noted, urgent diagnosis and treatment is necessary. Prior to neuraxial intervention the physician should consider the potential benefit versus the risk in anticoagulated patients or in patients to be anticoagulated for thromboprophylaxis.

### For indication-specific recommendations, please refer to the sections below:

- Prevention of stroke and systemic embolism in adult patients with NVAf
- Treatment of DVT and PE and prevention of recurrent DVT and PE in adult patients
- Treatment of VTE and prevention of VTE recurrence in children

There is no clinical experience with the use of 15 mg and 20 mg Xarelto tablets in adults nor with the use of Xarelto in children in these situations. To reduce the potential risk of bleeding associated with the concurrent use of Xarelto and neuraxial (epidural/spinal) anaesthesia or spinal puncture, consider the pharmacokinetic profile of Xarelto. Placement or removal of an epidural catheter or lumbar puncture is best performed when the anticoagulant effect of Xarelto is estimated to be low. However, the exact timing to reach a sufficiently low anticoagulant effect in each patient is not known and should be weighted against the urgency of a diagnostic procedure.

For the removal of an epidural catheter and based on the general pharmacokinetic characteristics, at least 2x half-life, i.e. at least 18 hours in young adult patients and 26 hours in elderly patients, should elapse after the last administration of Xarelto (see section 5.2 of the SmPC). Following removal of the catheter, at least 6 hours should elapse before the next Xarelto dose is administered. If traumatic puncture occurs, the administration of Xarelto is to be delayed for 24 hours.

No data is available on the timing of the placement or removal of a neuraxial catheter in children while on Xarelto. Discontinue Xarelto and consider a short-acting parenteral anticoagulant.

- Prevention of VTE in adult patients undergoing elective hip or knee replacement surgery

To reduce the potential risk of bleeding associated with the concurrent use of Xarelto and neuraxial (epidural/spinal) anaesthesia or spinal puncture, consider the pharmacokinetic profile of Xarelto.

Placement or removal of an epidural catheter or lumbar puncture is best performed when the anticoagulant effect of Xarelto is estimated to be low (see section 5.2 of the SmPC).

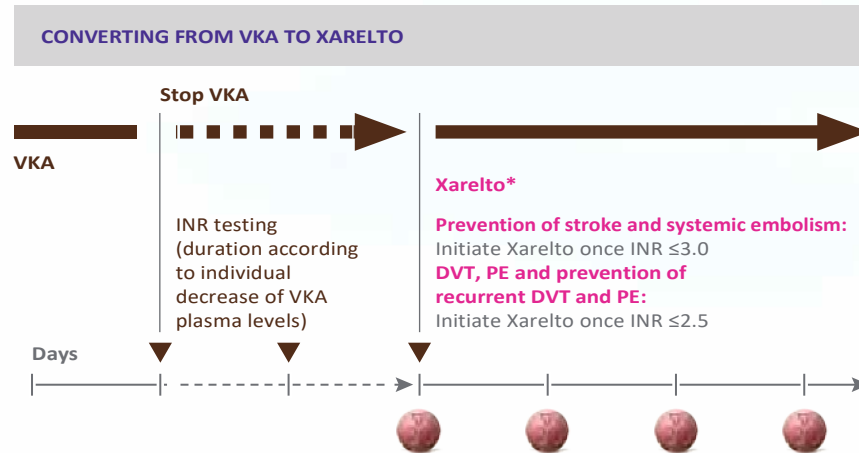
At least 18 hours should elapse after the last administration of Xarelto before removal of an epidural catheter. Following removal of the catheter, at least 6 hours should elapse before the next Xarelto dose is administered. If traumatic puncture occurs, the administration of Xarelto is to be delayed for 24 hours.

- Prevention of atherothrombotic events in adult patients with coronary artery disease (CAD) or symptomatic peripheral artery disease (PAD) at high risk of ischaemic events
- Prevention of atherothrombotic events in adult patients after an ACS with elevated cardiac biomarkers

There is no clinical experience with the use of Xarelto 2.5 mg with ASA alone or with ASA plus clopidogrel or ticlopidine in these situations. To reduce the potential risk of bleeding associated with the concurrent use of Xarelto and neuraxial (epidural/spinal) anaesthesia or spinal puncture, consider the pharmacokinetic profile of Xarelto.

Placement or removal of an epidural catheter or lumbar puncture is best performed when the anticoagulant effect of Xarelto is estimated to be low (see section 5.2 of the SmPC). However, the exact timing to reach a sufficiently low anticoagulant effect in each patient is not known. Platelet aggregation inhibitors should be discontinued as suggested by the manufacturer's prescribing information.

## Converting from VKA to Xarelto



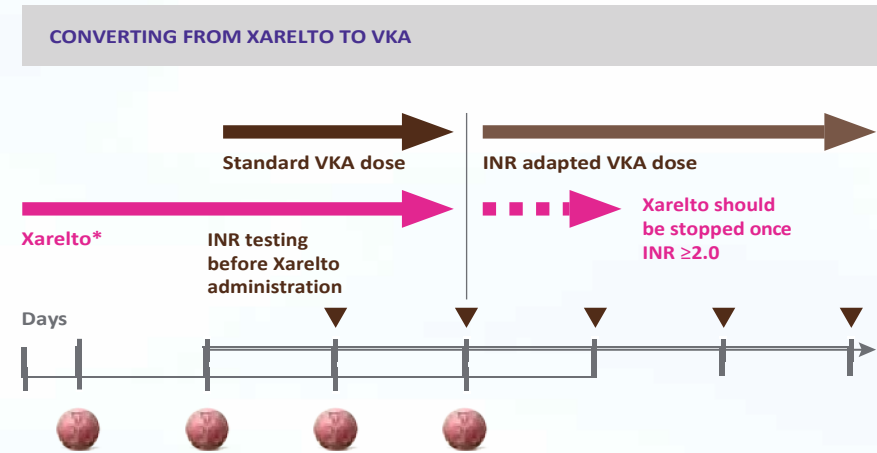
\* See dosing recommendations for required daily dose.

For patients treated for **prevention of stroke and systemic embolism**, treatment with VKA should be stopped and Xarelto therapy should be initiated when the **INR  $\leq 3.0$** .

For patients treated for **DVT, PE and prevention of recurrent DVT and PE**, treatment with VKA should be stopped and Xarelto therapy should be initiated when the **INR  $\leq 2.5$** .

INR measurement is not appropriate to measure the anticoagulant activity of Xarelto, and therefore should not be used for this purpose. Treatment with Xarelto only does not require routine coagulation monitoring.

## Converting from Xarelto to VKA



\* See dosing recommendations for required daily dose.

It is important to ensure adequate anticoagulation while minimising the risk of bleeding during conversion of therapy.

### Adults and children

When converting to VKA, Xarelto and VKA should be given overlapping until the **INR  $\geq 2.0$** . For the first 2 days of the conversion period, standard initial dosing of VKA should be used followed by VKA dosing guided by INR testing.

**INR measurement is not appropriate to measure the anticoagulant activity of Xarelto.** While patients are on both Xarelto and VKA, the **INR should not be tested earlier than 24 hours after the previous dose but prior to the next dose of Xarelto.** Once Xarelto is discontinued, INR values obtained at least 24 hours after the last dose reliably reflect the VKA dosing.

### Children

Children who convert from Xarelto to VKA need to continue Xarelto for 48 hours after the first dose of VKA. After 2 days of co-administration, an INR should be obtained prior to the next scheduled dose of Xarelto. Co-administration of Xarelto and VKA is advised to continue until the INR is  $\geq 2.0$ .

## Converting from parenteral anticoagulants to Xarelto

- Patients with a parenteral drug on a fixed dosing scheme such as low-molecular-weight heparin (LMWH): Discontinue parenteral drug and start Xarelto 0 to 2 hours before the time of the next scheduled administration of the parenteral drug
- Patients with a continuously administered parenteral drug such as intravenous unfractionated heparin: Start Xarelto at the time of discontinuation

## Converting from Xarelto to parenteral anticoagulants

Give the first dose of the parenteral anticoagulant at the time the next Xarelto dose would be taken.

## Populations potentially at higher risk of bleeding

Like all anticoagulants, Xarelto may increase the risk of bleeding.

Therefore, Xarelto is contraindicated in patients:

- With active clinically significant bleeding
- With lesion or condition, if considered to be a significant risk for major bleeding. This may include current or recent gastrointestinal ulceration, presence of malignant neoplasms at high risk of bleeding, recent brain or spinal injury, recent brain, spinal or ophthalmic surgery, recent intracranial haemorrhage, known or suspected oesophageal varices, arteriovenous malformations, vascular aneurysms or major intraspinal or intracerebral vascular abnormalities
- Receiving concomitant treatment with any other anticoagulants, e.g. unfractionated heparin (UFH), LMWHs (enoxaparin, dalteparin, etc.), heparin derivatives (fondaparinux, etc.), oral anticoagulants (warfarin, dabigatran etexilate, apixaban, etc.) except under the circumstances of switching anticoagulant therapy or when UFH is given at doses necessary to maintain an open central venous or arterial catheter
- With hepatic disease associated with coagulopathy and clinically relevant bleeding risk, including Child-Pugh class B and C cirrhotic patients

The risk of bleeding increases with increasing age.

Several subgroups of patients are at increased risk and should be carefully monitored for signs and symptoms of bleeding complications.

Treatment decision in these patients should be carried out after assessment of treatment benefit against the risk for bleeding.

## Patients with renal impairment

For adults, see dosing recommendations for patients with moderate (CrCl 30–49 ml/min) or severe (CrCl 15–29 ml/min) renal impairment. Xarelto is to be used with caution in patients with CrCl 15–29 ml/min and in patients with renal impairment\* concomitantly receiving other medicinal products that increase rivaroxaban plasma concentrations. Use of Xarelto is not recommended in patients with CrCl <15 ml/min.

In children aged  $\geq 1$  year no dose adjustment is required with mild renal impairment (glomerular filtration rate: 50–80 ml/min/1.73 m<sup>2</sup>). Xarelto is not recommended in children aged  $\geq 1$  year with moderate or severe renal impairment (glomerular filtration rate <50 ml/min/1.73 m<sup>2</sup>).

Xarelto is not recommended in children <1 year with serum creatinine results above 97.5<sup>th</sup> percentile, as no clinical data is available (see SmPC Granules for oral suspension for reference values).

## Patients concomitantly receiving other medicinal products

- Systemic azole-antimycotics (such as ketoconazole, itraconazole, voriconazole and posaconazole) or HIV protease inhibitors (e.g. ritonavir): use of Xarelto is not recommended
- Care is to be taken in patients concomitantly receiving drugs affecting haemostasis, such as non-steroidal anti-inflammatory drugs (NSAIDs), ASA, platelet aggregation inhibitors or selective serotonin reuptake inhibitors (SSRIs) and serotonin norepinephrine reuptake inhibitors (SNRIs)
- ACS patients and CAD/PAD patients: Patients on treatment with Xarelto and ASA or with Xarelto and ASA plus clopidogrel/ticlopidine should only receive concomitant treatment with NSAIDs if the benefit outweighs the bleeding risk
- The interaction with erythromycin, clarithromycin or fluconazole is likely not clinically relevant in most patients but can be potentially significant in high-risk patients (for patients with renal impairment see further above)

Interaction studies have only been performed in adults. The extent of interactions in the paediatric population is not known. The warnings above should be taken into account also for the paediatric population.

\* With moderate renal impairment (CrCl 30–49 ml/min) for Xarelto 2.5 mg and 10 mg.

## Patients with other haemorrhagic risk factors

As with other antithrombotics, Xarelto is not recommended in patients with an increased bleeding risk, such as:

- Congenital or acquired bleeding disorders
- Uncontrolled severe arterial hypertension
- Other gastrointestinal disease without active ulceration that can potentially lead to bleeding complications (e.g. inflammatory bowel disease, oesophagitis, gastritis and gastroesophageal reflux disease)
- Vascular retinopathy
- Bronchiectasis or history of pulmonary bleeding

## Other contraindications

Xarelto is contraindicated during pregnancy and breastfeeding. Women of childbearing potential should avoid becoming pregnant during treatment with Xarelto. Xarelto is also contraindicated in case of hypersensitivity to the active substance or to any of the excipients.

## Overdose

Due to limited absorption, a ceiling effect with no further increase in average plasma exposure is expected at supratherapeutic doses of 50 mg Xarelto and above in adults; however, no data is available at supratherapeutic doses in children. A decrease in the relative bioavailability for increasing doses (in mg/kg bodyweight) was found in children, suggesting absorption limitations for higher doses, even when taken together with food. A specific reversal agent antagonising the pharmacodynamic effect of rivaroxaban is available (refer to the Summary of Product Characteristics of andexanet alfa); however, it is not established in children. The use of activated charcoal to reduce absorption in case of overdose may be considered.

Should a bleeding complication arise in a patient receiving Xarelto, the next Xarelto administration should be delayed or treatment should be discontinued as appropriate. Individualised bleeding management may include:

- Symptomatic treatment, such as mechanical compression, surgical intervention, fluid replacement
- Haemodynamic support, blood product or component transfusion
- If bleeding cannot be controlled with the above measures, either the administration of a specific factor Xa inhibitor reversal agent (andexanet alfa) or a specific procoagulant reversal agent, such as prothrombin complex concentrate (PCC), activated prothrombin complex concentrate (APCC) or recombinant factor VIIa (r-FVIIa) should be considered. However, there is currently very limited clinical experience with the use of these medicinal products in adults and in children receiving Xarelto

Due to the high plasma protein binding, Xarelto is not expected to be dialysable.

## Coagulation testing

Xarelto does not require routine coagulation monitoring. However, measuring Xarelto levels may be useful in exceptional situations where knowledge of Xarelto exposure may help to take clinical decisions, e.g. overdose and emergency surgery.

Anti-FXa assays with Xarelto-specific calibrators to measure rivaroxaban levels are commercially available. If clinically indicated, haemostatic status can also be assessed by prothrombin time (PT) using Neoplastin as described in the SmPC.

The following coagulation tests are increased: PT, activated partial thromboplastin time (aPTT) and calculated PT INR. Since the INR was developed to assess the effects of VKAs on the PT, it is therefore not appropriate to use the INR to measure activity of Xarelto.

Dosing or treatment decisions should not be based on results of INR except when converting from Xarelto to VKA as described above.

ACS, acute coronary syndrome; ASA, acetylsalicylic acid; BID, twice daily; CAD, coronary artery disease; CrCl, creatinine clearance; DVT, deep vein thrombosis; GFR, glomerular filtration rate; HIV, human immunodeficiency virus; INR, international normalised ratio; LMWH, low-molecular-weight heparin; NSAID, non-steroidal anti-inflammatory drug; NVAf, non-valvular atrial fibrillation; OD, once daily; PAD, peripheral artery disease; PCI, percutaneous coronary intervention; PE, pulmonary embolism; SmPC, Summary of Product Characteristics; SPAf, stroke prevention in atrial fibrillation; TID, three times daily; VKA, vitamin K antagonist; VTE, venous thromboembolism; UFH, unfractionated heparin.

- ▼ **This medicinal product is subject to additional monitoring. This will allow quick identification of new safety information. Healthcare professionals are asked to report any suspected adverse reactions. See section 4.8 of the SmPC for how to report adverse events.**

## Dosing overview in adults\*

Indication <sup>1</sup>	Dosing <sup>1</sup>	Special populations <sup>1</sup>
Stroke prevention in adult patients with non-valvular atrial fibrillation <sup>†</sup>	<b>Xarelto 20 mg once daily</b>	In patients with impaired renal function with CrCl 15–49 ml/min <sup>†</sup> <b>Xarelto 15 mg once daily</b>  PCI with stent placement for a maximum of 12 months <b>Xarelto 15 mg once daily</b> plus a P2Y <sub>12</sub> inhibitor (e.g. clopidogrel)  PCI with stent placement in patients with impaired renal function with creatinine clearance 30–49 ml/min <sup>†</sup> <b>Xarelto 10 mg once daily</b> plus a P2Y <sub>12</sub> inhibitor (e.g. clopidogrel)
Treatment of DVT and PE, <sup>§</sup> and prevention of recurrent DVT and PE in adult patients	Treatment and prevention of recurrence, Day 1–21 <b>Xarelto 15 mg twice daily</b>  Prevention of recurrence from Day 22 onwards <b>Xarelto 20 mg once daily</b>  Extended prevention of recurrence, from Month 7 onwards <b>Xarelto 10 mg once daily</b>  Extended prevention of recurrence, from Month 7 onwards <b>Xarelto 20 mg once daily</b> in patients at high risk of recurrent DVT or PE, such as those:  • With complicated comorbidities  • Who have developed recurrent DVT or PE on extended prevention with Xarelto 10 mg	In patients with impaired renal function with CrCl 15–49 ml/min <sup>†</sup>  Treatment and prevention of recurrence, Day 1–21 <b>Xarelto 15 mg twice daily</b>  Thereafter <b>Xarelto 15 mg once daily</b> instead of Xarelto 20 mg once daily if patient's assessed risk for bleeding outweighs risk for recurrence  When the recommended dose is Xarelto 10 mg once daily, no dose adjustment is necessary
Prevention of VTE in adults undergoing elective hip or knee replacement surgery	<b>Xarelto 10 mg once daily</b>	

Indication <sup>1</sup>	Dosing <sup>1</sup>	Special populations <sup>1</sup>
Prevention of atherothrombotic events in adult patients with CAD or symptomatic PAD at high risk of ischaemic events	<b>Xarelto 2.5 mg twice daily in combination with acetylsalicylic acid</b> 75–100 mg/day	
Prevention of atherothrombotic events in adult patients after an ACS with elevated cardiac biomarkers	<b>Xarelto 2.5 mg twice daily in combination with standard antiplatelet therapy</b> (acetylsalicylic acid 75–100 mg/day alone or acetylsalicylic acid 75–100 mg/day plus clopidogrel 75 mg/day or a standard dose of ticlopidine)	

### **Xarelto 15 mg and 20 mg must be taken with food<sup>1</sup>**

For patients who are unable to swallow whole tablets, Xarelto tablet may be crushed and mixed with water or apple puree immediately prior to use and administered orally.

\* For dosing for the treatment of VTE and prevention of recurrence in paediatric patients, please refer to the body-weight-adjusted Xarelto dosing table on page 10.

† With one or more risk factors, such as congestive heart failure, hypertension, age ≥75 years, diabetes mellitus, prior stroke or transient ischaemic attack.

‡ Use with caution in patients with creatinine clearance 15–29 ml/min and in patients with renal impairment when concomitantly receiving other medicinal products that increase rivaroxaban plasma concentration.

§ Not recommended as an alternative to unfractionated heparin in patients with PE who are haemodynamically unstable or may receive thrombolysis or pulmonary embolectomy.

Reference: 1. Bayer AG. Xarelto® (rivaroxaban) Summary of Product Characteristics. Available at: [https://www.ema.europa.eu/documents/product-information/xarelto-epar-product-information\\_en.pdf](https://www.ema.europa.eu/documents/product-information/xarelto-epar-product-information_en.pdf).



## Local Safety Information

Suspected Adverse Drug Reactions (side effects) or medication errors may be reported using the Medicines Authority ADR reporting form, which is available online at <http://www.medicinesauthority.gov.mt/adrportal>, and sent by post or email to:

P: Pharmacovigilance Section at Post-Licensing Directorate, Medicines Authority, Sir Temi Żammit Buildings, Malta Life Sciences Park, San Ġwann SĠN 3000

E: [postlicensing.medicinesauthority@gov.mt](mailto:postlicensing.medicinesauthority@gov.mt)

Or

E: [pv@alfredgera.com](mailto:pv@alfredgera.com)

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