***Rivaroxaban (Xarelto) for Coronary Artery Disease:***

Rivaroxaban (*Xarelto*) was recently approved for use in patients with stable coronary artery disease (CAD) or peripheral artery disease (PAD). The rivaroxaban "vascular" dose is 2.5mg oral twice daily along with aspirin 81 mg per day to reduce cardiovascular (CV) events in chronic CAD or PAD patients.

The margin of benefit of adding rivaroxaban is small, so most patients will still likely be on aspirin alone. In addition, cost may be a limiting factor as rivaroxaban 2.5 mg twice daily is about $420/month.

In the COMPASS trial over 27,000 patients with stable CAD or PAD were randomly assigned to receive rivaroxaban (2.5 mg oral twice daily) plus aspirin, rivaroxaban alone, or aspirin alone with a mean follow up time of 23 months. Compared with aspirin alone, the combination of rivaroxaban plus aspirin reduced cardiovascular mortality and ischemic stroke significantly, but not the risk of myocardial infarction. In the Commander HF trial, over 5000 patients with CHF (EF<40%), CAD were randomly assigned to receive rivaroxaban 2.5mg oral twice daily compared to placebo. Patients continued to receive all standard of care medications for CHF and CAD (including aspirin). During the median follow up of 21 months, there was no significant difference in all cause mortality between rivaroxaban and placebo groups and the composite outcome of death, MI or stroke occurred at similar rates between the 2 groups. Severe bleeding (mostly GI bleeding) was higher in patients receiving rivaroxaban in both studies.

Based on this information, adding rivaroxaban 2.5mg oral twice a day along with aspirin may be considered for stable for patients with atherosclerotic cardiovascular disease who are at high risk for cardiovascular events and at low risk of bleeding. High risk patients may include those with multivessel CAD, diabetes, incomplete coronary revascularization, prior CABG, or multiple prior ischemic events.

Avoid starting rivaroxaban 2.5 mg twice daily for hospitalized CAD or PAD patients as it is not indicated for acute treatment.

For patients admitted on the combination of aspirin and rivaroxaban, continue it if there are no bleeding risks. It is also reasonable holding rivaroxaban 2.5 mg doses until discharge if patients cannot bring in their own supply. Currently the smallest formulary product size at Maui Health Systems is 10mg and it is not recommended to "quarter" a 10 mg tab to get 2.5 mg as this may lead to an inaccurate dose. Using aspirin alone for a few days isn't likely to increase CV risk. For patients unable to bring in their own supply and who will stay in the hospital for a prolonged course please submit a patient specific non-formulary request to the pharmacy if there is a desire to continue the medication.

If these patients need venous thromboembolism (VTE) prophylaxis, start subcutaneous unfractionated or low-molecular-weight heparin and hold home rivaroxaban 2.5 mg twice daily. There's no evidence this low strength will prevent a VTE.

Stay alert for mix-ups with apixaban (*Eliquis*). It may also be dosed 2.5 mg twice daily, but for different indications.

Continue to optimize other interventions for CAD and PAD patients such as [verifying statin use](https://hospital-pharmacist.therapeuticresearch.com/Content/Segments/PRL/2015/May/Lipid-Treatment-FAQs-8440) and offering smoking cessation.

Emphasize medication adherence since less than half of CAD patients stay on all of their medications that help reduce CV risk.

May I help you?

 

 **DRUG SHORTAGES**

 **IV HYDROMORPHONE**

 **IV FENTANYL**

 **IV Hydralazine**

 **DOBUTAMINE**

 **Bupivacaine**

 **AKWA tears**

 **IV Labetalol**

 **IV Sodium Bicarbonate**

 **IV Sodium Phosphate**

 **Lorazepam**

 **KAYEXALATE**

 **TOPICAL THROMBIN**

 **IV DIPHENHYDRAMINE**

 **For more information**

 **contact:**

 www.ashp.org/DrugShortages