Warfarin initiation protocol for patients older than 70 years old.

1. Assess patient’s age, sex, and risks for bleeding complications (see below)
2. If no high risks exist, start warfarin 4mg PO qday (give in the evening to allow time for morning INR result to come back)
3. Continue warfarin 4mg qday on day 1, 2, and 3.
4. On day 4, check INR in the morning. According to the result, adjust the dosage of warfarin as below:
   - INR 1.0 to 1.2       Increase to 5mg qday
   - INR 1.3 to 1.4       Continue 4mg qday
   - INR 1.5 to 1.6       Decrease to 3mg qday
   - INR 1.7 to 1.8       Decrease to 2mg qday
   - INR 1.9 to 2.4       Decrease to 1mg qday
   - INR 2.5 or higher    Measure INR daily and hold warfarin until INR drops to <2.5, then resume at 1mg qday.
5. Depending on the INR result and changes in the warfarin dosage, recheck INR in 1, 2, or 3 days.

High risks for bleeding or over-anticoagulation

- Women 80 years or older
- Anyone with current antibiotics, antifungals, aspirin, NSAID, amiodarone, and omeprazole
- Anyone with history of bleed, history of stroke, CRI, severe anemia, and uncontrolled HTN.
- If any of the high risk factors is present, then follow the adjusted protocol as follows
1. Start warfarin 3mg PO qday (give in the evening to allow time for morning INR result to come back)
2. Continue warfarin 3mg qday on day 1, 2, and 3.
3. On day 4, check INR in the morning. According to the result, adjust the dosage of warfarin as below:
   - INR 1.0 to 1.2       Increase to 4mg qday
   - INR 1.3 to 1.4       Continue 3mg qday
   - INR 1.5 to 1.6       Decrease to 2mg qday
   - INR 1.7 to 1.8       Decrease to 1.25mg qday (1/2 tablet of 2.5mg tablet)
   - INR 1.9 to 2.4       Decrease to 1mg qday
   - INR 2.5 or higher    Measure INR daily and hold warfarin until INR drops to <2.5, then resume at 0.5mg qday.
4. Depending on the INR result and changes in the warfarin dosage, recheck INR in 1, 2, or 3 days.