**Incentivisation Pace of Change – Best Value DOACs in Primary Care**

**Edoxaban change to Apixaban or Rivaroxaban**

NHS England guidance places apixaban and rivaroxaban as first choice DOACs[[1]](#footnote-2). Local specialist opinion would place apixaban as the preferred agent due to a small increased risk of gastrointestinal bleeding with rivaroxaban[[2]](#footnote-3),[[3]](#footnote-4). This risk can be described as 1.9 versus 1.4 major GI bleeds per 100 patient years when comparing rivaroxaban with apixaban. All changes should be completed after shared decision making with patients, recognising their preference in choice of either apixaban or rivaroxaban. recognising their preference in choice of either apixaban or rivaroxaban.

|  |  |  |
| --- | --- | --- |
| Eligible Patients | Scheme Specific Excluded Patients | DOAC Excluded Patients\* |
| Adult patients with a current repeat Edoxaban prescription, within the 3 months prior to the scheme start date | Has a previous adverse reaction to apixaban or rivaroxaban | Patients with prosthetic heart valves |
| Disability. Where patients are at increased risk from change in medicines causing confusion e.g. independent in medicines administration and visually impaired (see coding guidance below) | Patient is pregnant, breast-feeding or planning pregnancy |
| People co-prescribed strong inhibitor of P glycoprotein, CYP3A4, concomitant anticoagulation agent. |
| Patient has non-valvular AF  | Communication received from specialist, detailing clinical exemption to use of apixaban and rivaroxaban. | Creatinine clearance below 15ml/min  |
| Patients with recurrent DVT/PE | Patients with a bleeding disorder, antiphospholipid syndrome, or other lesion/condition considered a significant risk factor for major bleeding. |
|  | Patients being currently treated for a DVT / PE  | Patients with hepatic disease associated with coagulopathy and clinically relevant bleeding risk / severe hepatic impairment (moderate hepatic impairment for rivaroxaban).  |

* Listed DOAC exclusions are not exhaustive: please consult relevant medicine SPC/BNF for further information.

Change option 1: Convert Edoxaban dosing to Apixaban dosing

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Renal function and weight criteria | Edoxaban dose |  | Renal function and weight criteria | Apixaban dose |
| ≥61kg & > 50ml/min creatinine clearance | 60mg daily |  | Nil or 1 of the following:* < 60kg
* > 80 years
* serum creatinine ≥ 1.5 mg/dL (133 µmol/L)
 | 5mg twice a day |
| <61kg & >50ml/min creatinine clearance | 30mg daily |  | 2 or more of the following:* < 60kg
* > 80 years
* serum creatinine ≥ 1.5 mg/dL (133 µmol/L)
 | 2.5mg twice a day |
| 15-50ml/min creatinine clearance | 30mg daily |  | 15-29ml/min creatinine clearance  | 2.5mg twice a day |
| <15ml/min creatinine clearance | Not indicated |  | <15ml/min creatinine clearance | Not indicated unless specified by renal team |

Change option 2: Convert Edoxaban dosing to Rivaroxaban dosing

|  |  |  |
| --- | --- | --- |
| Renal function and weight criteria | Edoxaban dose | Equivalent Rivaroxaban dose |
| ≥60kg & >50ml/min creatinine clearance | 60mg | 20mg |
| <60kg & 50ml/min > creatinine clearance |  30mg | 20mg  |
| 15-49ml/min/BSA | 30mg | 15mg |
| <15ml/min/BSA | Not indicated | Not indicated |

Coding

|  |  |  |
| --- | --- | --- |
| Code | Term | Use |
| XaLTs | Anticoagulant therapy stopped | DOAC therapy stopped for clinical reason |
| Xad9s | Apixaban not tolerated | Exclusion from eligible cohort |
| XadAI | Apixaban contraindicated | Exclusion from eligible cohort |
| Xad9m | Apixaban adverse reaction | Exclusion from eligible cohort |
| Xad9t | Rivaroxaban not tolerated | Exclusion from eligible cohort |
| XadAK | Rivaroxaban contraindicated | Exclusion from eligible cohort |
| Xad9n | Rivaroxaban adverse reaction | Exclusion from eligible cohort |
| XaPT9 | Not suitable for switch to generic medication | Disability and self-administration of medicines e.g. visually impaired, explicit secondary care request to remain on edoxaban |

**Frequently Asked Questions**

**Which drugs are included in IPoC schemes for any given year?**

Drugs eligible for an IPoC scheme will be determined by the ICB after review by IMOC. Once a new opportunity is approved for addition to an IPoC programme, updated data schemes will be shared with PCNs, including information on scheme dates and payment terms.

**How is the length of IPoC scheme calculated?**

Each individual IPoC scheme will have a defined opportunity window. The length of each scheme will be set by the ICB. The scheme length is decided by considering the complexity of the switch and the volume of people needing to be contacted.

**How do we submit data for this IPoC scheme?**

Data will be collected automatically from SystmOne to avoid submission where possible. Where a template is necessary the deadline for submissions is the 15th day of the month, presenting cumulative data from the previous month(s).

Data on eligible patients at the start of the scheme will be published in SystmOne in Dorset SystmOne GPs / Medicines Optimisation folders.

**How will we be paid?**

Payments will be made from monthly data collated or submitted by the ICB based on specific IPoC returns the following month.

Payments will be dependent on the submissions received but will also be subject to ongoing validation.

**What if our submission is late?**

This will only apply if automated data collation cannot be used. If so then if your submission is late, then this will result in payment being delayed.

**What if we use the wrong template?**

The majority of data collected will be by SystmOne extract. In rare cases where template submission is required it is the responsibility of the provider to ensure the **current** IPoC template is being utilised, and any data is transferred from their previous versions to maintain a cumulative log of switching data. The current version will be clearly identified on the NHS Dorset Medicines Optimisation page [Medicine Value](https://nhsdorset.nhs.uk/medicines/value/)

**What if we have delays outside of our control?**

As part of the agreement to incentivise pace of change by providing recompense for the work completed from savings made on switches from the first 12 months (dependent on product) of best value product availability. If supply issues, outside of provider control, create a delay in the switch rate, this would be looked on a case-by-case basis.

**What data do we need?**

SystmOne extracts will identify the number of eligible patients repeat prescribed edoxaban at the start of the scheme and identify each month the number of people where the repeat prescription is stopped, and the new best value medicine repeat prescription is commenced and issued.

On the rare occasion a template is required the equivalent data applicable to the switch will be required.

**What if the price changes mid-IPoC scheme?**

Where a drug tariff price changes we will monitor the impact of this change and communicate with providers to ensure the scheme is still viable.

**What happens if new patients are started on the originator product?**

Patients initiated on originator products (edoxaban or dabigatran) during the course of the IPoC scheme will result in a claw-back value to be calculated on an individual basis.

**How will we validate your submissions?**

We will continually monitor your SystmOne returns and share those with each PCN. Should any manual returns be required any significant variations from your manually submitted returns will be raised with the provider via email.

We reserve the proviso to adjust any IPoC payments if there are discrepancies on the reported savings having been delivered.

**How do we ensure that there are no issues with data validation?**

1. Please inform us of any known issues with data delays and be clear at which stage you have reported the saving
2. Good data quality is essential so use of the Dorset formulary embedded in SystmOne will enable accurate data extraction.
3. Supply. We do not plan to launch the scheme until stable generic supply of preferred products are available. Where large variations in supply are experienced in good faith, we may extend the scheme length to enable providers to achieve the incentive.
4. All new patients should be initiated as default on the best value product from day 1 of the scheme.

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1. [NHS England » Commissioning recommendations for national procurement for direct-acting oral anticoagulant(s) (DOACs)](https://www.england.nhs.uk/publication/commissioning-recommendations-for-the-national-procurement-of-direct-acting-oral-anticoagulants-doacs/) [↑](#footnote-ref-2)
2. #  Oh HJ, Ryu KH, Park BJ, Yoon BH. The risk of gastrointestinal hemorrhage with non-vitamin K antagonist oral anticoagulants: A network meta-analysis. Medicine (Baltimore). 2021 Mar 19;100(11):e25216. doi: [10.1097/MD.0000000000025216](https://pubmed.ncbi.nlm.nih.gov/33726018/). PMID: 33726018; PMCID: PMC7982234.

 [↑](#footnote-ref-3)
3. Ingason AB et al. [Rivaroxaban Is Associated With Higher Rates of Gastrointestinal Bleeding Than Other Direct Oral Anticoagulants: A Nationwide Propensity Score–Weighted Study](https://pubmed.ncbi.nlm.nih.gov/34633836/). *Ann Intern Med* 2021;Oct 12: [↑](#footnote-ref-4)