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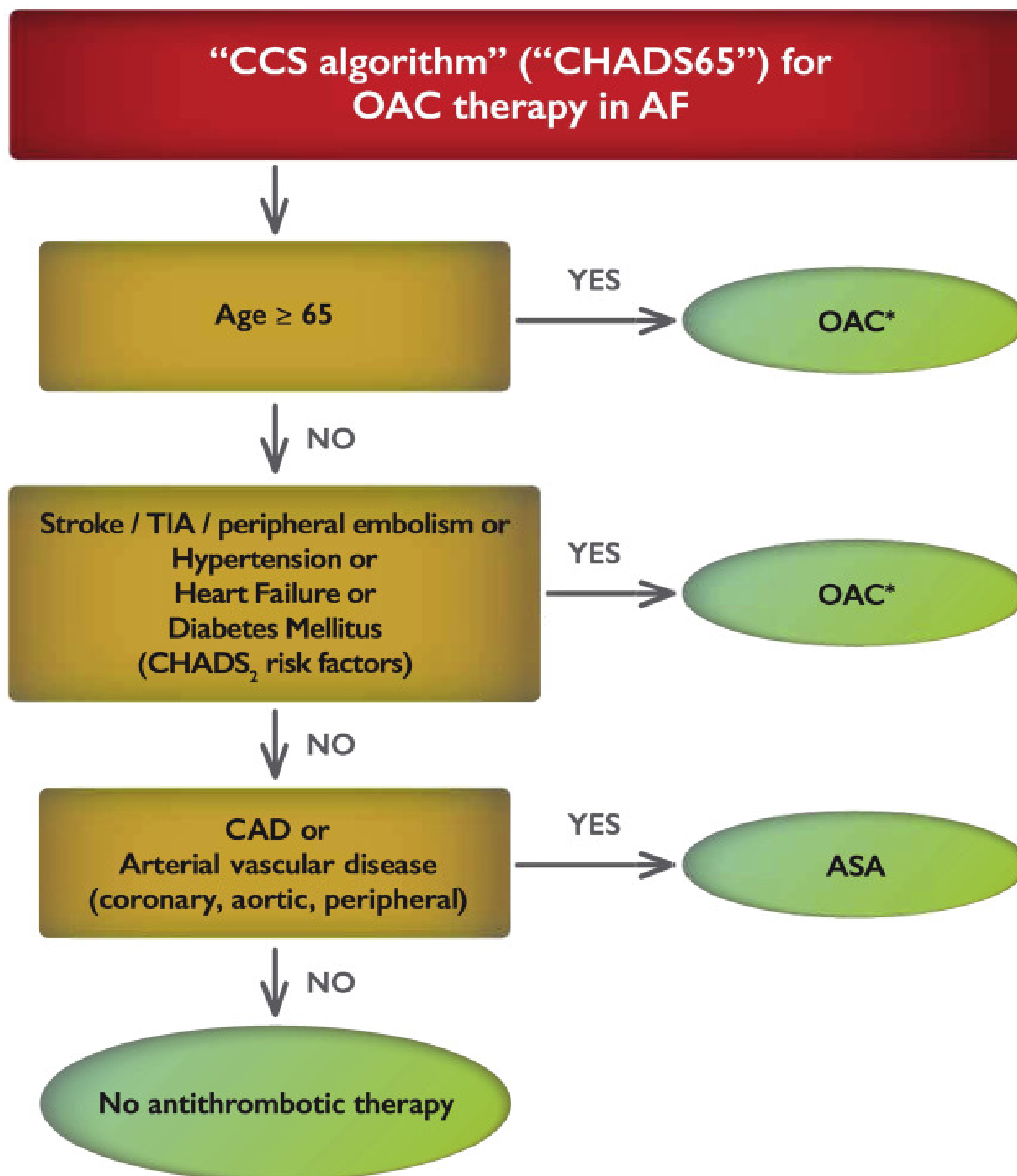
PRACTITIONER PRE-PRINTED ORDERS
Atrial Fibrillation / Atrial Flutter
Emergency Department



Macle L, Cairns J, Leblanc K, et al. 2016 focused update of the Canadian Cardiovascular Society guidelines for the management of atrial ibrillation for the CCS atrial fibrillation guidelines committee. 2016;32(10):1170-1185.doi:10.1016/j.cjca.2016.07.591

Addressograph

NAME: ______________________________

HSN: ______________________________

D.O.B.: ______________________________

[your logo here]

PRACTITIONER PRE-PRINTED ORDERS
Atrial Fibrillation / Atrial Flutter
Emergency Department

Addressograph or complete above section. Once completed and signed by prescriber, this is a Legal Prescription. Give to patient on discharge to fill at a Community Pharmacy.

Indication: Atrial fibrillation / atrial flutter - **stroke prevention** Duration of therapy: ____________________
$CHADS_2$ = _______ CrCl = ______ mL/min Weight = ______ kg

<table>
<tr><th rowspan="2">Medication Name / Dose / Directions for Use
Print legibly with black pen. Refer to ISMP Do Not Use Abbreviation List</th><th colspan="2">Prescription</th></tr>
<tr><th>Quantity</th><th>Refills</th></tr>
<tr><td>CrCl cutoff for use: apixaban = 25 mL/min, dabigatran and rivaroxaban = 30 mL/min. Rivaroxaban may be used with caution down to CrCl 15mL/min; however, there is limited clinical data to support use in this degree of renal impairment and these patients do not qualify for Exception Drug Status.
☐ apixaban 5 mg PO BID
☐ apixaban 2.5 mg PO BID (if 2 of 3: Age 80 or more, weight 60 kg or less, creatinine 133 umol/L or more)
☐ dabigatran 150 mg PO BID
☐ dabigatran 110 mg PO BID (if Age 80 or more, or Age 75 or more & 1 or more bleeding risk factor)
☐ rivaroxaban 20 mg PO once daily with food
☐ rivaroxaban 15 mg PO once daily with food (if CrCl 15-49 mL/min)

Recommended monitoring (separate lab requisition required):
• At least annually: Hemoglobin, liver function, and serum creatinine. Calculate creatinine clearance (CrCl) using Cockcroft- Gault equation for dose assessment.
• Every 6 months: serum creatinine if CrCl 30-60 mL/min or if on dabigatran and greater than 75 years of age or fragile. Monitor more frequently as required if a decline in renal or hepatic function is suspected.
• Date of follow up renal panel(s) post discharge: ___________________

☐ Meets the following Sask Drug Plan Exception Drug Status (EDS) or NIHB prior approval criteria for Afib (including stable renal function, no significant rheumatic mitral valve disease, and no mechanical heart valves)
    ☐ Anticoagulation is inadequate following a reasonable (2 month) trial on warfarin; Anticoagulation with warfarin is contraindicated or not possible due to inability to regularly monitor via International Normalized Ratio (INR) testing (i.e. no access to INR testing services at a laboratory, clinic, pharmacy, and at home).
☐ Does not meet Sask Drug Plan Exception Drug Status (EDS) or NIHB prior approval criteria for Afib. Patient aware of cost (~$100/month) and willing to pay.</td><td>34 days</td><td>X 1
or___</td></tr>
<tr><td>☐ warfarin
    warfarin 1 mg tablets plus
    warfarin 2.5 mg tablets, or ☐ 5 mg tablets if daily dose expected to be 5 mg or greater
    Sig: Take as directed to achieve target INR
Target INR: 2.5 (Range 2 – 3) ☐ 2.5-3.5 if mechanical valve ☐ other_____
First INR date post discharge (separate lab requisition required):____________________________</td><td>60 of each strength for dose titration</td><td>X 1
or___</td></tr>
<tr><td>☐ EC ASA 81mg PO once daily (normally not given in addition to OAC unless additional indication)
☐ clopidogrel 75 mg PO once daily</td><td>34 days</td><td>X 1
or___</td></tr>
</table>

Note: If patient receiving antiplatelet therapy prior to this prescription, intended plan for antiplatelet therapy:

PRESCRIBER'S SECTION *Contact family physician/RN(NP) for further refills.*

(Date/Time) ________________________________ Signature__________________________________

Print__________________________________

Addressograph

NAME: ______________________________

HSN: ______________________________

D.O.B.: ______________________________

[your logo here]

PRACTITIONER PRE-PRINTED ORDERS
Atrial Fibrillation / Atrial Flutter
Emergency Department

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Indication: Atrial fibrillation / atrial flutter – **rate or rhythm control**
Duration of therapy: ____________________

Medication Name / Dose / Directions for Use Print legibly with black pen. Refer to ISMP Do Not Use Abbreviation List	**Prescription** Quantity	Refills
☐ metoprolol _______ mg PO BID ☐ bisoprolol _______ PO daily ☐ dilTIAZem CD __________ mg PO daily ☐ digoxin _________ PO daily or _________	34 days	X 1 or___

Upon consultation with cardiologist:
☐ amiodarone Load (up to a total of 10 grams):
  ☐ 400 mg PO BID for _____ days; then start maintenance dose
  ☐ Other: ______________________________
☐ amiodarone Maintenance: 200 mg or _______ mg PO once daily
Recommended monitoring (in addition to baseline):
• Every 6 months: liver and thyroid function tests;
• Annually (minimally): ECG, chest x-ray
• As needed: pulmonary function tests and ophthalmic exam if visual impairment.
• Clinical evaluation/physical exam as needed for signs/symptoms toxicity (e.g., dermatologic, neurologic, ophthalmic, pulmonary effects).
☐ sotalol _________ mg PO BID or _______
Recommended monitoring (baseline and periodically): ECG (one week after starting), serum creatinine, magnesium, potassium, heart rate, blood pressure
☐ Pill-in-the-pocket:
  ☐ propafenone 600 mg PO x1 **OR** ☐ propafenone 450 mg PO x 1 if weight less than 70 kg
  AND
  ☐ metoprolol ______ mg (usual dose 25-50 mg) PO x 1 30-45 min prior to taking propafenone
  OR
  ☐ diltiazem IR ______ mg (usual dose 30-60 mg) PO x 1 30-45 min prior to taking propafenone
Directions for use: ______________________________. Do not repeat in less than 24 hours.
Recommended monitoring (baseline and periodically):
• ECG, heart rate, blood pressure, liver function tests (if symptomatic for hepatotoxicity)
	34 days	X 1 or___

Discontinue the following:	**Rationale:**

PRESCRIBER'S SECTION
Contact family physician/RN(NP) for further refills.

(Date/Time) ____________________________ Signature ______________________________

Print ______________________________

Version: Month Year
Approved by: Department of Emergency Medicine
Revision Date: Month Year

Form No.: PP-XXX