## Quick Reference Summary

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dose</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sub-therapeutic INRs if thrombotic risk very high</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Body Weight (kg)</td>
<td>Dose (units)</td>
<td></td>
</tr>
<tr>
<td>Less than 46</td>
<td>7 500 units once daily s/c</td>
<td>Until therapeutic levels are reached. Three doses would be appropriate to be prescribed in first instance, as most patients should reach therapeutic levels within this time.</td>
</tr>
<tr>
<td>46-56</td>
<td>10 000 units once daily s/c</td>
<td></td>
</tr>
<tr>
<td>57-68</td>
<td>12 500 units once daily s/c</td>
<td></td>
</tr>
<tr>
<td>69-82</td>
<td>15 000 units once daily s/c</td>
<td></td>
</tr>
<tr>
<td>Greater than 82</td>
<td>18 000 units once daily s/c</td>
<td></td>
</tr>
<tr>
<td><strong>VTE patients</strong></td>
<td></td>
<td>One initial dose only where patient presents outside of (or near to) VTE clinic opening hours.</td>
</tr>
<tr>
<td>Dose dependent on weight, full treatment dose as per table above (but with twice daily dosing for patients over 120 kg – see page 4) for 1st month (provided by secondary care) and then the dose reduced to the pre-filled syringe in the band below, i.e. to approx. 75-80% of full dose (table below shows dose from after month 1)</td>
<td></td>
<td>Secondary care will provide first month of treatment. Specialist review to be carried out at 3 months to decide on subsequent treatment.</td>
</tr>
<tr>
<td>Body Weight (kg)</td>
<td>Dose after month 1</td>
<td></td>
</tr>
<tr>
<td>Less than or equal to 57</td>
<td>7 500 units once daily s/c</td>
<td></td>
</tr>
<tr>
<td>57 to 68</td>
<td>10 000 units once daily s/c</td>
<td></td>
</tr>
<tr>
<td>69 to 82</td>
<td>12 500 units once daily s/c</td>
<td></td>
</tr>
<tr>
<td>83 to 98</td>
<td>15 000 units once daily s/c</td>
<td></td>
</tr>
<tr>
<td>Greater than or equal to 98</td>
<td>18 000 units once daily s/c</td>
<td></td>
</tr>
<tr>
<td><strong>IVDU patients</strong></td>
<td></td>
<td>full details around the dose, duration, reviews etc.</td>
</tr>
<tr>
<td>Sufficient written info should be provided alongside the TTO specifying full details around the dose, duration, reviews etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Patients with superficial thrombophlebitis</strong></td>
<td></td>
<td>Treatment usually for 6 weeks</td>
</tr>
<tr>
<td>We recommend an intermediate dose of dalteparin 125 units/kg s/c once daily (rounded to the nearest syringe)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prophylaxis in pregnancy</strong></td>
<td></td>
<td>Treatment for high risk patients should begin as soon as possible after positive pregnancy test and be continued until the patient attends their first appointment with the specialist, at which stage secondary care will assume responsibility for continued treatment. Referral for high risk patients (specified on page 8) should be marked as urgent.</td>
</tr>
<tr>
<td>High risk patients (specified on page 8):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight less than 50kg 2500 units once daily s/c</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight 50-90kg 5000 units once daily s/c</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight 91-130kg 7500 units once daily s/c</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight 131-170kg 10000units once daily s/c</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight greater than 170kg 75 units/kg once daily od s/c</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dalteparin 5000 units once daily s/c</td>
<td></td>
<td>Dalteparin should only rarely be recommended for this indication.</td>
</tr>
</tbody>
</table>

Approved by APCO January 15 Victoria Price Lead Anticoagulation & Thrombosis Pharmacist and Hannah Copus OCCG Pharmacist with advice from David Keeling Consultant Haematologist and Deborah Harrington Consultant Obstetrician. Version 1.0.

BACKGROUND

Historically patients requiring subcutaneous anticoagulation have received treatment through specialists and the acute sector. In recent years LMWH has effectively replaced the routine use of unfractionated heparin in the majority of patients. Use of LMWH has enabled once or twice daily subcutaneous injection, a reduced requirement for monitoring and the potential for patient self administration. Dalteparin is the LMWH of choice within Oxfordshire.

There are divergent professional views on the most appropriate place for the prescribing of LMWH. A general practitioner may rarely encounter such drugs commonly used by a specialist. Lack of familiarity with medication is an important cause of medication errors. It is therefore essential that care is only shared where it is in the best interests of the patient.

An NPSA alert has been published giving guidance on reducing treatment dose errors with LMWHs.

The following primary care guidance gives information for various indications including:

- Dosage
- Monitoring requirements
- Duration of treatment
- Shared Care arrangements

For several indications dalteparin has been agreed to be suitable for shared care. A shared care agreement outlines ways in which the responsibilities for managing the prescribing of a medicine can be shared between the specialist and a primary care prescriber. It should be noted that primary care prescribers are invited to participate. If they are unable to undertake these roles, then he or she is under no obligation to do so. In such an event, the total clinical responsibility for the patient for that diagnosed condition remains with the specialist.

These shared care agreements will often rely on the patient being able to self-administer and the specialist should ensure this is possible and the patient has been given sufficient advice and information before asking the GP to prescribe. Where this is not possible the GP may not be able to agree to shared care and the responsibility remains with the specialist.

Community nursing teams may be able to administer for some patients but this would need to be agreed individually before shared care commences.

Information around specific LMWH indications is given below, Ctrl & click on the following headings for links to each section:

- Perioperative anticoagulation ................................................................. 4
- LMWH for sub-therapeutic INRs ................................................................ 5
- Extended thromboprophylaxis: ................................................................. 5
- DVT patients: ................................................................................. 5
- VTE in patients with cancer .................................................................... 5
- VTE in IVDU patients: ........................................................................... 6
- Patients with superficial thrombophlebitis: ............................................. 7
- Pregnancy & postpartum ....................................................................... 7
- Long haul flight prophylaxis .................................................................. 8
General LMWH prescribing recommendations

Recommendation 1
LMWH treatment for four weeks or less should be prescribed and monitored by the initiating physician (any indication) unless covered by recommendation 2.

Recommendation 2
Treatment doses of LMWH in the following indications have been identified to be suitable for shared care: significantly sub therapeutic INRs within one month of acute VTE, DVT in patients with cancer, IVDU patients, post-op valve patients who require “bridging” and pregnant women with a high and intermediate risk of VTE (initial doses only whilst referral to a specialist is processed).
Shared care should be agreed in writing with an invitation to participate by consultant and response from the General Practitioner. For patients that are unable to self-inject shared care may not be suitable and prescribing would remain the responsibility of secondary care specialists.

Recommendation 3
Prophylactic doses of LMWH should normally be prescribed by secondary care. The following indications have been agreed as red, specialist prescribing only: peri-operative anti-coagulation, extended thromboprophylaxis & postpartum patients.

Recommendation 4
LMWH should very rarely be used for long haul flight prophylaxis and should be paid for by the patient. i.e. written on a private prescription

Please note practices that are near to the Royal Berkshire Hospital (RBS) may have patients that have received tinzaparin from RBS instead of dalteparin. Treatment with tinzaparin should reflect the indications and guidance that is within this document. See the Royal Berkshire Shared Care Guidelines for drug specific information for tinzaparin.

Dalteparin prescribing information

- **Adverse effects**
  Common side effects with dalteparin are subcutaneous haematomas at injection site, and mild thrombocytopenia, which tends to resolve with continued use. Immunologically mediated thrombocytopenia has also been observed.
  At recommended doses, bleeding occurs rarely. Transient, slight to moderate, elevations of liver transaminases have been observed but no clinical significance has been demonstrated.
  Refer to the SPC and BNF for a full list of adverse effects.

- **Contra-indications**
  Haemophilia and other haemorrhagic disorders, thrombocytopenia (including history of heparin-induced thrombocytopenia), recent cerebral haemorrhage, severe hypertension; peptic ulcer; after major trauma or recent surgery to eye or nervous system; acute bacterial endocarditis. See SPC / BNF for full list

- **Pregnancy & Breastfeeding**
  Does not cross the placenta; maternal osteoporosis reported after prolonged use. Not excreted into breast milk due to large molecular weight.

- **Drug interactions**
  NSAIDS, clopidogrel, dipyridamole and other oral anticoagulants increase risk of bleeding. See SPC / BNF for complete list.
• **Dose and administration:**
OUH treatment dose guidelines for therapeutic anticoagulation (e.g. acute VTE) are outlined in the table

<table>
<thead>
<tr>
<th>Body Weight (kg)</th>
<th>Dose (units)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 46</td>
<td>7 500</td>
</tr>
<tr>
<td>46-56</td>
<td>10 000</td>
</tr>
<tr>
<td>57-68</td>
<td>12 500</td>
</tr>
<tr>
<td>69-82</td>
<td>15 000</td>
</tr>
<tr>
<td>83-120</td>
<td>18 000</td>
</tr>
<tr>
<td>121-131</td>
<td>12,500 twice daily</td>
</tr>
<tr>
<td>132-143</td>
<td>15,000 mane &amp; 12,500 nocte</td>
</tr>
<tr>
<td>144-157</td>
<td>15,000 twice daily</td>
</tr>
<tr>
<td>158-172</td>
<td>18,000 mane &amp; 15,000 nocte</td>
</tr>
<tr>
<td>Greater than 172</td>
<td>18,000 twice daily</td>
</tr>
</tbody>
</table>

**Renal failure:**
In the case of significant renal failure, responsibility for treatment should lie with secondary care specialists.

**Children:**
Not recommended for children.

**Elderly:**
Dalteparin has been used safely in elderly patients without the need for dosage adjustment

**Administration:**
The subcutaneous injection should preferably be given into the abdominal subcutaneous tissue anterolaterally or posterolaterally, or into the lateral part of the thigh. Patients should be supine and the total length of the needle should be introduced vertically, not at an angle, into the thick part of a skin fold, produced by squeezing the skin between the thumb and forefinger; the skin fold should be held throughout the injection.

• **Preparations available**
2,500 units in 0.2mL fixed-dose syringe
5,000 units in 0.2mL fixed-dose syringe
7,500 units in 0.3mL fixed-dose syringe
10,000 units in 0.4mL fixed-dose syringe
12,500 units in 0.5mL fixed-dose syringe
15,000 units in 0.6mL fixed-dose syringe
18,000 units in 0.72mL fixed-dose syringe
10,000 units in 1 ml graduated syringe

• **Monitoring**
No monitoring of dalteparin in primary care is required in these cases. As patient’s weight is used as the basis for calculating the required treatment dose of LMWH however, the weight must be accurately recorded in kilograms (kg) in the clinical record. Patients should be weighed at the start of therapy and, where applicable, during treatment.

**Perioperative anticoagulation**
LMWH is required in some patients as peri-operative bridging when warfarin is stopped for an operation or invasive procedure. If LMWH is recommended, responsibility for advising the patient, informing the GP and prescribing should normally be undertaken by the hospital team performing the procedure. This aims to ensure that patients are provided with consistent timely advice and treatment by professionals familiar with perioperative anticoagulation. Patients will be attending a preoperative assessment clinic and those prescribed warfarin may be advised to switch to LMWH during the perioperative period. The duration of alternative therapy is usually less than a week but advice will be dependent on the complexity of the surgery and underlying thromboembolic risk.

Dalteparin for this indication should be arranged and provided by the team carrying out the procedure or operation and therefore remains classified as ‘red – specialist prescribing only’ on the Oxfordshire Prescribing Traffic Lights. On discharge patients may be given a supply of dalteparin. However if the INR continues to remain sub-therapeutic a small supply from the GP may be needed. Information on dosage will be included on the TTO and only a very short term supply would be necessary until this is achieved. This is believed to be exceptional and should be very occasional.

**LMWH for sub-therapeutic INRs**

Patients on warfarin who are at high risk of thromboembolism (e.g. VTE within the previous month) may require LMWH if the International Normalised Ratio (INR) becomes significantly sub-therapeutic, this would be continued until their INR returns to target range.

Dalteparin for this indication is classified on the Oxfordshire prescribing traffic lights as Yellow, suitable for shared care. Prescribing may be carried out in primary care in line with the shared care guidance & information below:

Three doses would be appropriate to be prescribed in first instance, as most patients should reach therapeutic levels within this time.

- **Shared Care Responsibilities**
  - Shared care assumes communication between the Anticoagulation Service / VTE Service, GP and patient.
  - **Anticoagulation Service / VTE Service**
    - Identify to the GP a patient with sub-therapeutic INR who requires therapy with dalteparin
    - Telephone the GP requesting shared care. Outline shared care protocol criteria.
    - Liaise with GP regarding dose of dalteparin and likely duration of therapy.
    - Ensure clinical and laboratory supervision of the patient is done.
    - Ensure the patients understand the nature and complications of drug therapy and their role in reporting adverse effects promptly.
    - Notify the GP and patient when therapy with dalteparin can cease
    - Be available to give advice to GP and patient at all times.
  - **GP**
    - Prescribe dalteparin at the dose and frequency advised by the Anticoagulation Service.
    - Advise the Anticoagulation Service of any clinical deteriorations and monitor for adverse effects as appropriate
  - **Patient**
    - Report any adverse effects to their GP and/or to the Anticoagulation Service
    - Have regular blood tests as outlined above

**Extended thromboprophylaxis:**

In some patients extended thromboprophylaxis (i.e hip replacement, hip fracture, trauma patients, major cancer surgery in the abdomen or pelvis) with LMWH is recommended after discharge. This indication is classified as ‘red - for specialist prescribing only’ and the supply should be arranged and provided by the surgical team.

**VTE patients:**

Practices signed up to the dalteparin DVT service specification provide a triage service by undertaking initial clinical assessment, D-Dimer testing and referring those identified to be at risk of a DVT to the DVT clinic. Where a patient with a suspected DVT is seen in primary care outside opening hours of the DVT clinic, a single dose of LMWH should be given and the patient advised to attend the DVT clinic the following day. This may be given by the GP or the patient can be referred to the John Warin ward at the Churchill for a single dose. Attending the Churchill however may result in long waiting times.
for the patient as they must be reviewed again prior to receiving the dose. Should the GP prefer to provide the first dose and does not keep a stock of dalteparin, it is essential that stock is confirmed with a pharmacy before the patient is given the prescription as not all pharmacies will stock all strengths of dalteparin injection. Dalteparin for the first dose for DVT patients when outside of DVT clinic hours has been classified as green, suitable for primary care prescribing, on the Oxfordshire Prescribing Traffic Lights.

### VTE in patients with cancer


For this indication, dalteparin has been classified as yellow, suitable for shared care, within the Oxfordshire Prescribing Traffic Lights.

Patients are referred to the DVT clinic, usually from general practice. If a DVT is diagnosed in a patient with an underlying malignancy, current OUH protocol recommends the patient is considered for continuing LMWH rather than warfarin. Full dose LMWH is given for the first month and then the dose is reduced thereafter (see page 1 for dose table), i.e. to approx 75-80% of full dose (unless patient <46 or >98kg). This is dependent on either the patient or a relative being able to administer. Alternatively, an oral anticoagulant (warfarin, apixaban or rivaroxaban) will be initiated. The OUH will provide the first 28 days supply of dalteparin and refer to the GP to suggest a shared care protocol is agreed for further treatment.

The licensed total duration of treatment is 6 months. This is based on Lee et al (2003) who performed their trial when six months was standard for all acute VTE. However, VTE patients are now usually reviewed at three months to decide on subsequent management. The appropriateness of continuing anticoagulation beyond this period will be evaluated by the secondary care specialist according to individual risk/benefit ratio, taking into account particularly the progression of cancer. Where the patient is not under the care of an oncologist, the VTE service will carry out this review. If the cancer persists some form of continuing anticoagulation is usually recommended.

In the case of significant chemotherapy-induced thrombocytopenia (platelet counts less than 50 x 10⁹/l), advise should be sought from haematology (coagulation and haemostasis SpR bleep 5529 or 01865 225320).

Patients with cancer often experience dramatic shifts in weight, therefore this should be monitored to ensure dose adjustment is carried out where necessary.

- **Shared Care Responsibilities:**
  Shared care assumes communication between the oncologist (or VTE service where the patient is not under the care of an oncologist), the GP and the patient.

#### VTE Service/OUH
- Initiate treatment and prescribe first 4 weeks of therapy.
- Send a letter to the GP requesting shared care. For patients not receiving active management by the oncologist, the shared care is requested between the GP & VTE service.

#### Hospital Oncologist/VTE service
- Liaise with GP regarding changes in disease management, drug dose, and missed clinic appointments.
- Ensure the patients understand the nature and complications of drug therapy and their role in reporting adverse effects promptly.
- Be available to give advice to GP and patient at all times.
- Decide on management after three months of dalteparin is completed.

#### GP
- Prescribe dalteparin according to dosing schedule outlined on page 1.
- Advise the hospital consultant of any clinical deteriorations and monitor for adverse effects as appropriate.
- Monitor weight regularly and adjust dose accordingly where necessary.
**Patient**
Report any adverse effects to their GP and/or specialist
Have regular blood tests as requested by the GP/specialist

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**VTE in IVDU patients:**

LMWH, apixaban or rivaroxaban may be more appropriate for intravenous drug abusers who may have difficult venous access and who often comply poorly with warfarin treatment. Intravenous drug users requiring dalteparin would normally be supplied 7-14 days on the TTO (quantity being dependent on safety considerations), with the remainder of the course being supplied by the GP. A letter containing sufficient written info should be provided alongside the TTO specifying details around the dose, duration, reviews etc.

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**Patients with superficial thrombophlebitis**

The most commonly affected superficial veins are the long (great) and short saphenous veins of the leg. Referral for investigation at the DVT clinic should not normally be necessary for a short segment of below knee SVT unless concomitant DVT is suspected. Patients who are referred with suspected concomitant DVT are assessed for DVT. If during this investigation it is found that SVT is adjacent to (within 3 cm of) the sapheno-femoral junction (SFJ) the DVT clinic will treat with therapeutic anticoagulation for three months (as for DVT) as there is a high risk of progression to DVT (Tait, et al 2012). A three month review is not required.

Otherwise SVT has been considered to be a benign and self-limiting condition and in the past was treated exclusively with non-steroidal anti-inflammatory drugs (NSAIDs). Although this is reasonable for mild cases it has become recognised that more severe cases have a better symptomatic response to anticoagulation. Patients with mild SVT (e.g. less than 5 cm in length) can be treated with NSAIDs but patients with more severe disease (e.g. more than 5 cm in length) may be better treated with an intermediate dose of LMWH for six weeks (Cosmi, et al 2012, Scott, et al 2015) as this has been shown to provide better symptomatic relief. The suggested dosing is dalteparin at approximately 125 units/kg daily (rounding to the nearest syringe). Prophylactic dose of fondaparinux (2.5 mg daily) is an alternative (Decousus, et al 2010).

Dalteparin is traffic lighted within the Oxfordshire PCT traffic light list as green for this indication, meaning it may be initiated and prescribed in primary care.


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**Pregnancy & postpartum**

It is essential that patients with a high risk of thromboembolism receive preconception counselling at an early stage, via referral to the Silver Star Obstetric physician/haematology team for expert advice.

Royal College of Obstetrics and Gynaecology (RCOG) states;
‘antenatal thromboprophylaxis should begin as early in pregnancy as practical. Individuals with recurrent VTE are at increased risk of further recurrence and many will be on long-term warfarin. Although data are lacking, it would be expected that they would have a high risk of recurrence in pregnancy. Advice should be sought from a clinician with expertise in haemostasis and pregnancy... Women should be counselled about the risks of warfarin to the fetus and advised to stop warfarin and change to LMWH as soon as pregnancy is confirmed, ideally within two weeks of the missed period and before the sixth week of pregnancy. Women not on warfarin should be advised to start LMWH as soon as they have a positive pregnancy test.’

In line with this guidance, antenatal patients identified as high risk (as per indications specified below) should begin treatment with dalteparin as soon as a pregnancy is confirmed with a positive pregnancy test. In order to avoid delay, it

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would therefore be appropriate for GPs to provide this therapy whilst waiting for a referral to the Silver Star obstetric team to be processed. Further guidance on dalteparin treatment will then be provided by the specialist.

**High risk patients:**
- Single previous VTE and thrombophilia or family history (1<sup>st</sup> degree relative)
- Single unprovoked/oestrogen related VTE
- Previous recurrent VTE >1

Referrals should be marked as urgent for high risk patients.

**Dose for high risk pregnancy prophylaxis:**
- Weight less than 50kg 2500 units od
- Weight 50-90kg 5000 units od
- Weight 91-130kg 7500 units od
- Weight 131-170kg 10000 units od
- Weight more than 170kg 75 units/kg od

**Intermediate risk patients:**
Intermediate risk patients should be referred to the obstetric team for consideration of whether antenatal prophylaxis is required. Further guidance on dalteparin thromboprophylaxis will then be provided by the specialist.
- Single previous provoked VTE, with no family history orthrombophilia
- Thrombophilia but no history of VTE
- Medical co-morbidities e.g. heart/lung disease, SLE, cancer, inflammatory conditions, nephritic syndrome, sickle cell disease, IVDU
- Surgical procedure in pregnancy e.g. appendectomy

Dalteparin is classified on the Oxfordshire Prescribing Traffic Lights as **yellow, suitable for shared care** for high risk pregnancy patients to allow for initial doses to be given as soon as a pregnancy is confirmed. For intermediate risk patients dalteparin is classified as red-specialist initiation only.

**PostPartum:**
Most patients recommended postnatal LMWH will only require seven days treatment. Six weeks supply is appropriate in high risk groups or for women with greater than three persisting risk factors.

LMWH is appropriate for postpartum thromboprophylaxis although, if women are receiving long term anticoagulation with warfarin, this can be started when the risk of haemorrhage is low, usually 7-14 days after delivery.

Women delivering at the John Radcliffe or Horton will have the full 7 days (or where appropriate 6 weeks) course of dalteparin supplied at discharge it is therefore classified as **red, specialist prescribing only** for this indication. Note this excludes women delivering at home and in midwifery led units.

**Long haul flight prophylaxis**

LMWH is only rarely recommended for this indication. Below is a summary from British Committee for Standards in Haematology Guidelines on Travel-related Venous Thrombosis:

<table>
<thead>
<tr>
<th>Duration of travel Risk Group</th>
<th>&lt; 3 hours</th>
<th>3-8 hours</th>
<th>&gt; 8 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
</tr>
<tr>
<td>Intermediate</td>
<td>Nil</td>
<td>Nil or stockings</td>
<td>Stockings</td>
</tr>
<tr>
<td>High</td>
<td>Nil</td>
<td>Stockings</td>
<td>Stockings +/- Anticoagulant</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Group</th>
<th>Examples of risk factors for VTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>None</td>
</tr>
<tr>
<td>Intermediate</td>
<td>All others e.g. Up to 6 weeks post-partum. Previous unprovoked VTE no longer on anticoagulants. Previous travel-related VTE Combinations of risk factors.</td>
</tr>
</tbody>
</table>
For high risk patients stockings with or without anti-coagulant is recommended, dalteparin use for flight prophylaxis should therefore be exceptional in patients identified as very high risk only. If uncertain, advice may be sought from haematology.

Dalteparin is therefore classified on the Oxfordshire Prescribing Traffic Lights as **brown, restricted prescribing** for this indication.

### In Summary

<table>
<thead>
<tr>
<th>Indication</th>
<th>Traffic Light</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perioperative anticoagulation</td>
<td>Specialist prescribing only</td>
<td></td>
</tr>
<tr>
<td>Extended thromboprophylaxis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-partum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trauma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intermediate risk in pregnancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sub-therapeutic INRs</td>
<td>Transfer of prescribing to primary care in line with shared care protocol</td>
<td></td>
</tr>
<tr>
<td>DVT in patients with cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV drug users</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High risk in pregnancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long haul flight prophylaxis</td>
<td>Prescribe only in restricted circumstances</td>
<td></td>
</tr>
<tr>
<td>Presentation of VTE outside of VTE clinic opening hours</td>
<td>Suitable for prescribing in primary care</td>
<td>In line with DVT service specification. One off, initial dose only, if outside of DVT clinic hours.</td>
</tr>
</tbody>
</table>