Appendix A-7f: Atrial Fibrillation Center of Excellence Pharmacy Follow-Up Visit

[Insert Health System name]: Pharmacist Atrial Fibrillation Medication Management Clinic

Patient Name:
Patient MRN:
DOB Age Gender:

Date:
Time:

Your patient has been followed by the [Insert Health System name] Atrial Fibrillation Medication Management Clinic and is now due for their yearly renewal. I have reviewed the patient's chart to assess the appropriateness of their current therapy.

A brief treatment summary is copied below. For further details specifically regarding this patient's anticoagulation management, please refer to the AMS icon in the header of the patient's EHR profile.

Anticoagulant:
Target INR Range (if applicable):

Rate Control Agent:

Rhythm Control Agent:

For [Insert Health System name] Atrial Fibrillation Medication Management Clinic to continue management, please complete the yearly renewal in the EHR.

Thank you for your help in ensuring the safe and effective treatment of your patient. If there have been any changes to your patient's plan, please note that on the renewal.

_____
[Insert name], RPh

[Insert Health System name]: Pharmacist Atrial Fibrillation Medication Management Clinic

Patient Name:
Patient MRN:
DOB Age Gender:

Date:
Time:

Referral Reason: Asked to manage atrial fibrillation/atrial flutter medication
Indication for referral:
Resting HR Goal:
Exercise HR Goal:
Current Atrial Fibrillation Regimen (if applicable):
Duration of Therapy:

Referring attending MD (The referral for atrial fibrillation medication management was made to Dr. XXX who referred the patient to be managed by a pharmacist in the [Insert Health System name] Pharmacist Atrial Fibrillation Medication Management Clinic).

Consult Received: The [Insert Health System name] Pharmacist Atrial Fibrillation Medication Management Clinic will manage the atrial fibrillation medication therapy for [Insert patient name] based on the above indication. All recommendations made under the [Insert Health System name] Pharmacist Atrial Fibrillation Medication Management Clinic will be documented in the EHR including, but not limited to, initiation, modification or discontinuation of a patient's medications and tests ordered. For daily progress notes and daily direct patient care notes, please contact the clinic directly for access.

Consent: I have reviewed the [Insert Health System name] Pharmacist Atrial Fibrillation Medication Management Clinic Patient Agreement Form with the patient. I have discussed with the patient their condition as well as the risks, benefits, and alternatives associated with their treatment and with no treatment. I have given the patient and family the opportunity to ask questions and, at this time, all of their questions have been answered to their satisfaction. The patient has given consent to have their condition managed within this collaborative practice.

New Patient Education Completed: Patient/family member has been educated and verbalized understanding of the indication for atrial fibrillation medication, the importance of adherence to medication dose/schedule, follow-up with the clinician for laboratory testing to assess clinical improvement and toxicity, blood pressure measurements and heart rate measurements per clinician instruction, potential medication interactions, and cardiovascular risks associated with their disease state.

For any questions or concerns, please feel free to contact the [Insert Health System name] Pharmacist Atrial Fibrillation Medication Management Clinic service via email [Insert email address]. For urgent issues please call [Insert telephone number].

Please NOTE: All referrals will expire annually OR upon completion of the indicated duration of therapy, whichever comes first. Our service will contact you at this time with a renewal request and your patient's treatment summary.

_____
[Insert name], RPh

Signed,
Referring Prescribers

Thank you for the referral of [Insert name] [Insert MRN]. We will be attempting to contact the patient over the next 2 business days. Once they have been contacted and officially enrolled in the [Insert Health System name] Pharmacist Atrial Fibrillation Medication Management Clinic we will write a note in EPIC and notify participating providers via for the EPIC in-basket. The responsibility of atrial fibrillation medication management remains with the referring physician or his/her delegate until the confirmation is received.

If we are unable to contact the patient within 1 week, we will contact you to let you know.

Please NOTE: All referrals will expire annually OR upon completion of the indicated duration of therapy, whichever comes first. Our service will contact you at this time with a renewal request and your patient's treatment summary.

Please feel free to contact us at any time with questions.

Sincerely,

_____
[Insert name], RPh

6-Minute Walk Test Instructions and Tracking Sheet
Instructions

- The goal of the 6-Minute Walk Test (6MWT) is to walk for 6 minutes. You are allowed to slow down, stop, and rest as necessary. If you need to rest, try to start walking again as soon as you are able
- Ideally, aim for a level of moderate activity. This will be different for each patient but should challenge you to push past a comfortable activity level

Activity Level	Descriptive Measure
Sedentary	Activities that have little additional movement
Light	An activity that does not cause a noticeable change in breathing. Feels easy
Moderate	An activity that is challenging but able to be conducted while maintaining a conversation uninterrupted. Feels like fast walking
Vigorous	An activity in which a conversation generally cannot be maintained uninterrupted. Feels like running

- Wear comfortable clothing and shoes
- Bring any walking aids (if you normally use them) such as walkers or canes
- It is ok to eat a small meal before your walk test
- Take all your usual medications
- Do not perform any vigorous exercise 2 hours prior to your 6MWT
- No warm-up is required
- Please fill out the table attached below for each 6MWT you complete

Measurements

- You will need to measure your heart rate (HR) and, if available, your oxygen saturation (SpO2) prior to your 6MWT
    - Prior to beginning your test, you should be resting comfortably for about 10 minutes
    - During this time when you are resting before your test, please measure your HR and SpO2
- Three minutes into your 6MWT, please measure your HR and SpO2
- After you have completed your 6MWT, we will also need you to check your HR and SpO2 again, as well as document any symptoms you experienced during the test
    - For example: Did you need to take a break at any point during the 6MWT?
    - What symptoms did you experience?
        - Chest pain, shortness of breath, fatigue, dizziness

6-Minute Walk Test (6MWT) Questionnaire

Date/Time:	
What was your Heart Rate before the 6MWT (at 0 minutes)?	BPM
If available, what was your Oxygen Saturation before the test?	%
What was your Heart Rate at 3 minutes?	BPM
If available, what was your Oxygen Saturation at 3 minutes?	%
What was your Heart Rate after the 6MWT (at 6 minutes)?	BPM

If available, what was your Oxygen Saturation after the 6MWT?	%
Did you have any symptoms during the 6MWT such as chest pain, shortness of breath, fatigue, dizziness?	Yes or No
If you did experience symptoms during your test, please note what you experienced.	Symptoms, if applicable:
How many times (if any) did you have to take a break during your 6MWT?	Number of breaks taken:
Any additional information you would like your clinician to know	

Safety Reminders

- Watch for symptoms of chest pain and/or shortness of breath unrelated to poor physical health
- Stop the 6MWT and call your doctor or Atrial Fibrillation Medication Management Clinic right away if any of the following occurs
    - SpO2 <85%
    - Intolerable shortness of breath
    - Lack of coordination and/or mental confusion
    - Leg cramps or extreme leg muscle fatigue
    - Staggering
    - Extreme fatigue
    - Excessive sweating
    - Lightheadedness and/or dizziness
    - Pale or ashen appearance
- If you plan to perform the 6MWT during our off hours and you experience any of the above symptoms, please report to the nearest emergency department and/or page an Atrial Fibrillation Center of Excellence doctor for consideration of emergency care

Adapted from the following references:

5. ATS Committee on Proficiency Standards for Clinical Pulmonary Function Laboratories. ATS statement: guidelines for the six-minute walk test. *Am J Respir Crit Care Med*. 2002;166(1):111-117. doi:10.1164/ajrccm.166.1.at1102
6. American Association of Heart Failure Nurses. Six Minute Walk Test Instructions and Tracking Sheet. Accessed January 23, 2024. https://cdn.ymaws.com/www.aahfn.org/resource/resmgr/docs/awareness/2017_HF_Week/6_Minute_Walk_Test_Instructi.pdf

Blood Pressure Technique

- Avoid caffeine, alcohol, tobacco, and exercise for at least 30 minutes before measuring your blood pressure
- Take your blood pressure in the morning before medications
- Sit quietly for 5 minutes before you measure your blood pressure.
- During the measurement, sit in a chair with your feet on the floor, not crossed, and your arm supported so your elbow is at about heart level. You might need to place a pillow or cushion under your arm to elevate it high enough
- Make sure the inflatable part of the cuff completely covers at least 80% of your upper arm. If it doesn't, you'll need a larger cuff. Place the cuff on bare skin, not over a shirt or a jacket. The tube coming out of the cuff should be facing down toward your hand.

Measure your blood pressure twice, with a brief break (about 1–2 minutes) in between. Do not get up in between readings, continue to relax.

[Insert Health System name] Atrial Fibrillation Medication Management Clinic
Part of the [Insert Health System name] Atrial Fibrillation Center of Excellence (AF CoE)

Patient Name:
Patient MRN:
DOB:
Age:
Gender:

Date:
Time:

Referral Reason: Asked to manage atrial fibrillation/atrial flutter medication

Indication for referral:

Resting HR Goal:

Current Atrial Fibrillation Regimen (if applicable):

Duration of Therapy:

Current Meds:

Progress Note:

Yours sincerely,

_____
[Insert name], RPh
Advanced Practice Clinical Pharmacist
[Insert Health System name] Atrial Fibrillation Center of Excellence (AF CoE)
[Insert telephone number]
[Insert email address]

Referral accepted documentation:

Referring attending MD (The referral for atrial fibrillation medication management was made to [Insert name(s)] who referred the patient to be managed by a pharmacist in the [Insert Health System name] Atrial Fibrillation Medication Management Clinic.

Consult Received: The BWH Atrial Fibrillation Medication Management Clinic will manage the atrial fibrillation medication therapy for [Insert patient name], [Insert patient MRN] based on the above indication. All recommendations made under the Insert Health System name] Atrial Fibrillation Medication Management Clinic will be documented in EPIC including, but not limited to, initiation, modification or discontinuation of a patient's medications and tests ordered. For daily progress notes and daily direct patient care notes, please contact the clinic directly for access.

Consent: I have reviewed the Insert Health System name] Atrial Fibrillation Medication Management Clinic Patient Agreement Form with the patient. I have discussed with the patient their condition as well as the risks, benefits, and alternatives associated with their treatment and with no treatment. I have given the patient and family the opportunity to ask questions and, at this time, all of their questions have been answered to their satisfaction. The patient has given consent to have their condition managed within this collaborative practice.

New Patient Education Completed: Patient/family member has been educated and verbalized understanding of the indication for atrial fibrillation medication, the importance of adherence to medication dose/schedule, follow-up with the clinician for laboratory testing to assess clinical improvement and toxicity, blood pressure measurements and heart rate measurements per clinician instruction, potential medication interactions, and cardiovascular risks associated with their disease state.

For any questions or concerns, please feel free to contact the [Insert Health System name] Pharmacist Atrial Fibrillation Medication Management Clinic service via email [Insert email address]. For urgent issues please call [Insert telephone number].

Please NOTE: All referrals will expire annually OR upon completion of the indicated duration of therapy, whichever comes first. Our service will contact you at this time with a renewal request and your patient's treatment summary.

_____

[Insert name], RPh
Advanced Practice Clinical Pharmacist
[Insert Health System name] Pharmacy Department
[Insert telephone number].
[Insert email address]

[Insert referring attending MD information]

[Insert Health System name] Anticoagulation Management Service (AMS)

Patient Name:
Patient MRN:
DOB:
Age:
Gender:

Date:
Time:

Referral Reason: Asked to manage anticoagulation therapy

Indication for Anticoagulation:

Anticoagulant Regimen:

Target INR (if applicable):

Duration of Therapy:

Referring attending MD (The referral for anticoagulation management was made to Dr. Jean Connors who referred the patient to be managed by a pharmacist in the Anticoagulation Management Service):

Consult Received: The [Insert Health System name] Anticoagulation Management Service will manage the anticoagulation for [Insert patient name], [Insert patient MRN] based on the above indication. For daily progress notes and dosing instructions please click on the AMS indicator in the patient header in EPIC and an anticoagulation report will display on the right side of the screen.

Consent: I have reviewed the AMS Patient Agreement Form with the patient. I have discussed with the patient their condition as well as the risks, benefits, and alternatives associated with their treatment and with no treatment. I have given the patient and family the opportunity to ask questions and, at this time, all of their questions have been answered to their satisfaction. The patient has given consent to have their condition managed within this collaborative practice.

New Patient Education Completed: Patient/family member has been educated and verbalized understanding of the indication for anticoagulation, the importance of adherence to medication dose/schedule and follow-up with AMS clinician and laboratory testing per clinician instruction, potential food/medication interactions, clotting risks associated with their disease state, and bleeding risks associated with anticoagulants.

For any questions or concerns, please feel free to contact the AMS service via email Insert email address] or via an EPIC In-basket message to the [Insert Health System name] Anticoagulation Clinic FD Pool. For urgent issues, please call [Insert telephone number].

_____

[Insert name], RPh
Advanced Practice Clinical Pharmacist
[Insert Health System name] Pharmacy Department
[Insert telephone number].
[Insert email address]

[Insert information for cc to Hematology Department]

Atrial Fibrillation Effect on QualiTy-of-life (AFEQT) Questionnaire

Patient Name:
Patient MRN:
DOB:
Age:
Gender:

Date:
Time:

SECTION 1

Are you currently in atrial fibrillation:
__Yes
__No

If No, when was the last time you were aware of having had an episode of atrial fibrillation? (Please check 1 answer that best describes your situation):
__Earlier today
__1 month to 1 year ago
__Within the past week
__More than 1 year ago
__Within the past month
__I was never aware of having atrial fibrillation

SECTION 2

The following questions refer to how atrial fibrillation affects your quality of life.

On a scale of 1 to 7 (1=Not at all or no symptom, 7=Extremely), over the past 4 weeks, as a result of your atrial fibrillation, how much were you bothered by:

1. Palpitations: Heart fluttering, skipping, or racing: 1-7

2. Irregular heartbeat: 1-7

3. A pause in heart activity 1-7

4. Lightheadedness or dizziness: 1-7

On a scale of 1 to 7, over the past 4 weeks, have you been limited by your atrial fibrillation in your:

1. Ability to have recreational pastimes, sports, and hobbies: 1-7

2. Ability to have a relationship and do things with friends and family: 1-7

On a scale of 1 to 7, over the past 4 weeks, as a result of your atrial fibrillation, how much difficulty have you had in:

1. Doing any activity because you felt tired, fatigued, or low on energy: 1-7

2. Doing physical activity because of shortness of breath: 1-7

3. Exercising: 1-7

4. Walking briskly: 1-7

5. Walking briskly uphill or carrying groceries or other items, up a flight of stairs without stopping: 1-7

6. Doing vigorous activities such as lifting or moving heavy furniture, running, or participating in strenuous sports like tennis or racquetball: 1-7

On a scale of 1 to 7, over the past 4 weeks, as a result of your atrial fibrillation, how much did the feelings below bother you?

1. Feeling worried or anxious that your atrial fibrillation can start anytime: 1-7

2. Feeling worried that atrial fibrillation may worsen other medical conditions in the long run: 1-7

On a scale of 1 to 7, over the past 4 weeks, as a result of your atrial fibrillation treatment, how much were you bothered by:

1. Worrying about the treatment side effects from medications: 1-7

2. Worrying about complications or side effects from procedures like catheter ablation, surgery, or pacemaker therapy: 1-7

3. Worrying about side effects of blood thinners such as nosebleeds, bleeding gums when brushing teeth, heavy bleeding from cuts, or bruising: 1-7

4. Worrying or feeling anxious that your treatment interferes with your daily activities: 1-7

On a scale of 1 to 7, overall, how satisfied are you at the present time with:

1. How well your current treatment controls your atrial fibrillation: 1-7

2. The extent to which treatment has relieved your symptoms of atrial fibrillation: 1-7

Yours sincerely,

_____

[Insert name], RPh
Advanced Practice Clinical Pharmacist
[Insert Health System name] Atrial Fibrillation Center of Excellence (AF CoE)
[Insert telephone number]
[Insert email address]

[Insert Health System name and contact information]

Atrial Fibrillation Medication Management Patient Agreement
Welcome to the [Insert Health System] Atrial Fibrillation Medication Management Clinic

What will the pharmacists managing your rate control medications do?

- The clinic will provide information about risks and benefits of rate control medications, including the risks and benefits of no medicine as an option
- The clinic will provide you with a blood pressure cuff
- The clinic will provide information about how to take a proper reading of your blood pressure, heart rate, and heart rhythm
- The clinic will contact you via telephone (or by an alternative method if applicable) for follow-up of rate control medicines
- The clinic will answer your phone call or patient ortal messages, Monday through Friday from 9:00 AM to 4:30 PM
- The clinic will write your rate control medication prescription(s)
- The clinic will call you on a regular basis to assess adherence to your medication regimen and ensure you are not having trouble getting it from your pharmacy, ask about any signs or symptoms of atrial fibrillation, ask about other side effects of your rate control medications, and may ask you to take additional blood pressure or heart rate readings when needed
- The clinic may leave a voicemail containing readings and recommendations on the phone number that you have indicated is your preferred contact line

What will the pharmacists managing your rhythm control medications do?

- The clinic will provide information about the risks and benefits of rhythm control medications, including the risks and benefits of no medicine as an option
- The clinic will contact you via telephone (or by an alternative method if applicable) for follow-up of rhythm control medicines
- The clinic will answer your phone call or patient portal messages, Monday through Friday from 9:00 AM to 4:30 PM
- The clinic will track and order necessary labs as needed
- The clinic will screen electrocardiogram for possible heart-wave prolongation and any possible adverse drug events or drug-to-drug interactions

What will I do?

- You will take your medicines as instructed by the pharmacist at the clinic
- You will take blood pressure and heart rate readings and report any symptoms related to your atrial fibrillation or side effects potentially related to your medications used to control your heart rate
- You will have a working phone number or active patient portal account so that the clinic can reach you

When will I call the Atrial Fibrillation Medication Management Clinic?

You will call the Atrial Fibrillation Medication Management Clinic at [Insert phone number] if you

- Have any signs of shortness of breath, dizziness, racing heart, or other symptoms you believe could be associated with any of your medications used to control your heart rate
- Are hospitalized for a reason related to atrial fibrillation
- Are told by another doctor or nurse to change or stop your rate control medications for any reason
- Miss a dose or take the wrong dose of your rate control medication(s)
- Need a new prescription for your rate control medication(s)
- Change your phone number or email for patient portal communication

What will happen if I do not follow up with the Atrial Fibrillation Medication Management Clinic?

- The clinic will continue to try to reach you up to 4 times via phone or Patient portal message for follow-up and management
- After the fourth time, the clinic will reach out to your referring physician for assistance in contacting you
- If we are still unable to obtain readings or contact you, the clinic will send a letter informing you that we will no longer be able to manage your rate control medicine if you do not respond within the time specified in the letter
- This policy is for your safety and will help us figure out a different arrangement that may better fit your needs

If you do not understand or cannot follow the responsibilities outlined above, please contact our service at [Insert phone number].

By continuing care in our clinic, you agree to these terms and consent to the Collaborative Drug Therapy Management Protocol.

[Insert Health System name and contact information]

Hello from the [Insert Health System name] Atrial Fibrillation Medication Management Clinic:

Welcome to our service. You have been referred to us by your physician for the management of your atrial fibrillation. Specifically, we manage the medications used to control your heart rate and/or rhythm while you are in atrial fibrillation. This pharmacist-run clinic is a service provided to you in conjunction with our cardiologists and is dedicated to caring for patients with atrial fibrillation who require medications. Not all patients will require the same doses or medications and so we individualize each medical regimen based on how you respond. Our service is made up of pharmacists, pharmacy interns, and administrative personnel.

Your doctor has recommended that a pharmacist manage your rate control therapy under a Collaborative Drug Therapy Management (CDTM) protocol. Under this protocol, the pharmacist will prescribe your rate control medication and work closely with your doctor to manage your symptoms associated with atrial fibrillation.

We are committed to providing you with the highest level of patient care and safety. We ask for a high level of commitment from you so that we can work together for your benefit.

Please review the Patient Agreement Form provided and call us with any questions or concerns. We look forward to working with you.

Insurance Coverage

- Virtual visits with the pharmacist are considered a hospital outpatient visit.
- Your insurance will be charged by the hospital for use of hospital resources, equipment, and staff. This is commonly known as a “Facility Fee.” Most often there is no out-of-pocket fee but depending on your insurance you may have some cost-sharing responsibility (or out-of-pocket fees).
- Typically visits with the pharmacist will minimize additional physician visits to optimize your medication therapy.
- To find out if your health insurance covers nutrition, please call the 800 number on your insurance card.

Sincerely,

_____

[Insert name], RPh
Advanced Practice Clinical Pharmacist
[Insert Health System name] Pharmacy Department
[Insert telephone number].
[Insert email address]

[Insert referring attending MD information]

Warfarin Drug Information

Pronunciation: WAR far in
Brand: Coumadin, Jantoven

What is the most important information I should know about warfarin?

You should not take warfarin if you have a bleeding disorder, blood in your urine or stools, stomach bleeding, an infection of the lining of your heart, bleeding in your brain, recent or upcoming surgery, or if you need a spinal tap or epidural. **Do not take warfarin if you cannot take it on time every day**.

Do not use warfarin if you are pregnant unless your doctor tells you to.

While using warfarin, you will need frequent "INR" or prothrombin time tests to measure your blood-clotting time.

Warfarin increases your risk of bleeding, which can be severe or life-threatening. Call your doctor or seek emergency medical attention if you have bleeding that will not stop, if you have black or bloody stools, or if you cough up blood or vomit that looks like coffee grounds.

Many drugs can cause serious medical problems when used with warfarin. Tell your doctor about all medicines you have recently used.

What is warfarin?

Warfarin is an anticoagulant (blood thinner). Warfarin reduces the formation of blood clots.

Warfarin is used to prevent heart attacks, strokes, and blood clots in veins and arteries.

Warfarin may also be used for purposes not listed in this medication guide.

What should I discuss with my health care provider before taking warfarin?

You should not take warfarin if you are allergic to it, or if you have:

- hemophilia or any bleeding disorder that is inherited or caused by disease;
- a blood cell disorder (such as low red blood cells or low platelets);
- blood in your urine or stools, or if you have been coughing up blood;
- an infection of the lining of your heart (bacterial endocarditis);
- stomach or intestinal bleeding or ulcer;
- recent head injury, aneurysm, or bleeding in the brain; or
- if you undergo a spinal tap or spinal anesthesia (epidural).

You should not take warfarin if you cannot be reliable in taking it because of alcoholism, psychiatric problems, dementia, or similar conditions.

Warfarin can make you bleed more easily, especially if you have:

- a history of bleeding problems;
- high blood pressure or severe heart disease;
- kidney or liver disease;
- cancer;
- a disease affecting the blood vessels in your brain;
- a history of stomach or intestinal bleeding;
- a surgery or medical emergency, or if you receive any type of injection (shot);
- if you are 65 or older; or
- if you are severely ill or debilitated.

To make sure warfarin is safe for you, tell your doctor if you have:

- celiac sprue (an intestinal disorder);
- diabetes;
- congestive heart failure;
- overactive thyroid;
- recent or upcoming surgery on your brain, spine, or eye;
- a connective tissue disorder such as Marfan Syndrome, Sjogren syndrome, scleroderma, rheumatoid arthritis, or lupus;
- a hereditary clotting deficiency (warfarin may make your symptoms worse at first);
- if you use a catheter; or
- if you have ever had low blood platelets after receiving heparin.

Do not use warfarin if you are pregnant unless your doctor tells you to. Warfarin can cause birth defects, but preventing blood clots in certain women may outweigh any risks to the baby. Use effective birth control to prevent pregnancy during treatment. Tell your doctor right away if you become pregnant. It is not known whether warfarin passes into breast milk or if it could harm a nursing baby. **Tell your doctor if you are breast-feeding a baby**.

How should I take warfarin?

Follow all directions on your prescription label. Your doctor may occasionally change your dose to make sure you get the best results. Do not take warfarin in larger or smaller amounts or for longer than your doctor tells you to.

Take warfarin at the same time every day, with or without food. **Never take a double dose of this medicine**.

While using warfarin, you will need frequent "INR" or prothrombin time tests (to measure how long it takes your blood to clot). You may not notice any change in your symptoms, but your blood work will help your doctor determine how long to treat you with warfarin. You must remain under the care of a doctor while using warfarin.

If you have received warfarin in a hospital, call or visit your doctor 3 to 7 days after you leave the hospital. Your INR will need to be tested at that time. **Do not miss any follow-up appointments**.

Tell your doctor if you are sick with diarrhea, fever, chills, or flu symptoms, or if your body weight changes.

You may need to stop taking warfarin 5 to 7 days before having any surgery or dental work. Call your doctor for instructions. You may also need to stop taking warfarin for a short time if you need to take antibiotics, or if you need to have a spinal tap or spinal anesthesia (epidural).

Wear a medical alert tag or carry an ID card stating that you take warfarin. Any medical care provider who treats you should know that you are using this medicine.

Store at room temperature away from heat, moisture, and light.

What happens if I miss a dose?

Take the missed dose as soon as you remember. Skip the missed dose if it is almost time for your next scheduled dose. **Do not take extra medicine to make up for the missed dose**.

What happens if I overdose?

Seek emergency medical attention or call the Poison Help line at 1-800-222-1222. **Overdose can cause excessive bleeding**.

What should I avoid while taking warfarin?

Avoid activities that may increase your risk of bleeding or injury. Use extra care to prevent bleeding while shaving or brushing your teeth. **You may still bleed more easily for several days after you stop taking warfarin**.

Ask your doctor before taking any medicine for pain, arthritis, fever, or swelling. This includes acetaminophen (Tylenol), aspirin, ibuprofen (Advil, Motrin), naproxen (Aleve), celecoxib (Celebrex), diclofenac, indomethacin, meloxicam, and others. **These medicines may affect blood clotting and may also increase your risk of stomach bleeding**.

Avoid making any changes in your diet without first talking to your doctor. Foods that are high in vitamin K (liver, leafy green vegetables, or vegetable oils) can make warfarin less effective. If these foods are part of your diet, eat a consistent amount on a weekly basis.

Grapefruit juice may interact with warfarin and lead to unwanted side effects. **Avoid the use of grapefruit products while taking warfarin**.

What are the possible side effects of warfarin?

Get emergency medical help if you have any of these **signs of an allergic reaction**: hives; difficult breathing; swelling of your face, lips, tongue, or throat.

Warfarin may cause you to bleed more easily, which can be severe or life-threatening. Seek emergency medical attention if you have any unusual bleeding, or bleeding that will not stop. You may also have bleeding on the inside of your body, such as in your stomach or intestines. Call your doctor at once if you have black or bloody stools, or if you cough up blood or vomit that looks like coffee grounds. These could be signs of bleeding in your digestive tract.

Also call your doctor at once if you have:

- pain, swelling, hot or cold feeling, skin changes, or discoloration anywhere on your body;
- sudden and severe leg or foot pain, foot ulcer, purple toes or fingers;
- sudden headache, dizziness, or weakness;
- easy bruising, purple or red pinpoint spots under your skin, bleeding from wounds or needle injections;
- pale skin, feeling light-headed or short of breath, rapid heart rate, trouble concentrating;
- dark urine, jaundice (yellowing of the skin or eyes);
- little or no urinating;
- numbness or muscle weakness; or
- pain in your stomach, back, or sides.

Common side effects may include:

- nausea, vomiting, mild stomach pain;
- bloating, gas; or
- altered sense of taste.

This is not a complete list of side effects and others may occur. Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

What other drugs will affect warfarin?

Many drugs (including some over-the-counter medicines and herbal products) can affect your INR and may increase the risk of bleeding if you take them with warfarin. Not all possible drug interactions are listed in this medication guide. It is very important to ask your doctor before you start or stop using any other medicine, especially:

- other medicines to prevent blood clots;
- medicine to treat any type of infection, including tuberculosis;
- supplements that contain vitamin K;

- **an antidepressant** – citalopram, duloxetine, fluoxetine, fluvoxamine, paroxetine, sertraline, venlafaxine, vilazodone, and others; **seizure medicine** – carbamazepine, phenobarbital, phenytoin; **herbal (botanical) products** – coenzyme Q10, cranberry, echinacea, garlic, ginkgo biloba, ginseng, goldenseal, or St. John's wort.

This list is not complete and many other drugs can interact with warfarin. This includes prescription and over-the-counter medicines, vitamins, and herbal products. Give a list of all your medicines to any healthcare provider who treats you.

Where can I get more information?

Your pharmacist can provide more information about warfarin.

Remember, keep this and all other medicines out of the reach of children, never share your medicines with others, and use this medication only for the indication prescribed.