Anticoagulation in COVID-19 at BMC

**Standard DVT Prophylaxis**
- Admission with Asymptomatic COVID or Incidental COVID diagnosis
- Admitted directly to the ICU or severe COVID (requiring >20L high flow oxygen, non-invasive ventilation, intubation, or use of vasopressors)*
- No clinical evidence or concern for VTE/clotting and no other indication for anticoagulation.
- No bleeding or profound thrombocytopenia or coagulopathy with platelets < 25K or fibrinogen <0.5

**Full Dose Anticoagulation**
- Admission with Symptomatic COVID without critical illness (requiring < 20L high flow oxygen with no need for ventilatory support or vasopressors) and acceptable bleeding risk*#
- Confirmed VTE or high clinical suspicion for VTE but unable to obtain confirmatory testing
- Established reason for therapeutic AC (Afib, prosthetic valve, etc.)**
- HD/CVVHD with clotting of dialysis tubing or lines resulting in repeated interruptions of therapy

**Unfractionated SQ Heparin Prophylaxis**
- 5,000 units three times daily for BMI ≤40 and weight <120kg
- 7,500 units three times daily for BMI >40 or weight >120kg

**CrCL ≥ 30mL/min**
- Standard Intensity Enoxaparin Prophylaxis
  - 40 mg once daily for BMI ≤40 and weight <120kg
  - 40 mg twice daily for BMI >40 or weight >120kg
  
**CrCL < 30mL/min**
- Unfractionated SQ Heparin Prophylaxis
  - 5,000 units three times daily for BMI ≤40 and weight <120kg
  - 7,500 units three times daily for BMI >40 or weight >120kg

**Full Anticoagulation with Enoxaparin**
- 1 mg/kg twice daily

**CrCL < 30mL/min**
- Unfractionated Heparin Infusion (Bolus and Standard aPTT Goal 55-90)
  - 80 units/kg bolus then infusion of 18 units/kg/hr for BMI <30 or 15 units/kg/hr for BMI >30
  - Consider Anti-Xa level if poor response to treatment or additional thrombosis suspected

**Outpatient anticoagulation regimen may continue prior anticoagulation regimen if deemed appropriate.**

*Preliminary data suggests a benefit of therapeutic anticoagulation in Symptomatic COVID patients requiring non-ICU level of care on preventing progression to requiring organ support (ventilator support or vasopressors)

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# May continue therapeutic anticoagulation if transferring from the floor to the ICU