AAVBC

American Academy of Value Based Care

Anticoagulation Therapy Utilization Management

Quick Reference Guide

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AAVBC Anticoagulation Therapy Utilization Management - Quick Reference Guide

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1. LANDSCAPE AND UTILIZATION OF ANTICOAGULANTS IN VBC

Anticoagulants are life-saving, typically chronic medications that reduce the likelihood of recurrent venous thromboembolic events following **(un)provoked Venous Thromboembolisms (VTE)** or prophylactically for **atrial fibrillation (AF)** patients. **AF affects more than 6 million people in the United States** (prevalence exceeding 9%–10% among adults ≥80 years) and **900,000 people are affected by VTE** per year, which together account for **220,000-320,000 annual deaths**.[1] In 2023 alone, **over $25.1 billion** in Medicare Part D spending was exclusively on anticoagulant therapies (**second highest drug RISK STRATIFICATION class in Medicare Part D spending**).[2]

Value-based care in anticoagulant therapies seeks to provide patients with the most **efficacious** and **cost-effective** disease management tools. The AAVBC supports effective and efficient utilization of anticoagulants which **reduce avoidable hospital admissions**, and promote responsible **stewardship of therapy duration** to prevent stroke and recurrent VTE.

Thromboembolic Diseases are Managed Using a Diverse Palette of Drugs

Clinicians now navigate a broad and evolving therapeutic landscape for thromboembolic disease. **VTEs** are primarily managed with anticoagulants, including **direct oral anticoagulants (DOACs)**, **warfarin**, and titratable **low–molecular-weight heparin or intravenous, direct thrombin inhibitors.**[3,4] In contrast, **arterial thromboembolic events** are typically managed with **antiplatelet therapies**[5–7] (*Please refer to the AAVBC QRG: Antiplatelet Therapy Utilization*), with one notable exception being the anticoagulant **rivaroxaban** (Xarelto; 2.5 mg BID) for use in **Coronary Artery Disease (CAD)** and **Peripheral Artery Disease (PAD)** in combination with antiplatelet therapies.[6,7] In select acute, life-threatening presentations, **thrombolytic (fibrinolytic) agents** may be administered in monitored hospital settings to **actively dissolve established clots.**

Contemporary guidelines from the American College of Cardiology (ACC), American Heart Association (AHA), American College of Chest Physicians (CHEST), and other expert bodies emphasize that therapeutic selection of thromboembolic modulators **must be individualized based on:**[3,4,8,9]

- Confirmed clinical indication
- Presence of **mechanical heart valves**, moderate-to-severe **mitral stenosis,** or **WATCHMAN implants**
- **Stroke risk assessment** (**CHA_2DS_2-VASc Score** for AF patients)
- Bleeding risk assessment (**HAS-BLED score)**
- Age, bodyweight, and renal and hepatic function
- Patient-specific comorbidities and contraindications (e.g., **antiphospholipid syndrome**, drug allergies or intolerances, bleeding disorders)
- Drug-drug interactions
- Access to and appropriateness of anticoagulant/antiplatelet reversal agents

DOACs are generally preferred over warfarin for most patients with nonvalvular AF (**NVAF**) and for the treatment of many VTE cases.[3,4] At first glance, this may seem paradoxical, as **DOACs often cost more than 100 times the price of warfarin**.[10] However, DOACs are usually the appropriate option because of

their **improved safety profile**, **fewer drug–drug and dietary interactions**, and **lower risk of intracranial hemorrhage and gastrointestinal bleeding**.[4,8,11] However, important contraindications can prevent DOAC use. Appropriate anticoagulant drug selection, dosing, renal function monitoring, and periodic reassessment remain essential to ensure safe and effective therapy. **In VTE management**, **treatment duration** should reflect whether the event was provoked or unprovoked as well as the individual patient's bleeding risk.[3,4]

Value-Based Care in Anticoagulant Therapies is a Careful Balance

The central clinical imperative—and the primary value-based lever—is clear: **Prevent thromboembolic events while minimizing avoidable bleeding and fragmentation of care**.

AAVBC Tip: A key mechanism of achieving value-based care for anticoagulant therapies is through the use of **low-cost, generic anticoagulants whenever appropriate**. High-quality anticoagulation management enhances patient safety, preserves functional independence, and reduces avoidable utilization driven by preventable complications.

Prevalence and Clinical Context

Anticoagulation in older adults

Thromboembolic Risk	Bleeding Risk
AF patients are 5x more likely to suffer from ischemic strokes[12]	NVAF patients receiving DOACs and valvular AF patients receiving warfarin are at greater risk of GI bleeds
Unprovoked VTE patients may be in hypercoagulable states (potentially cancer-associated thrombosis)[3,9]	Cancer-associated thrombophilia requires chronic, long-term anticoagulation therapy which enhances bleeding risk
Hospitalized, immobile patients (post hip and knee surgery) are at higher provoked VTE risk due to venous stasis[3,9]	Anticoagulant prophylaxis leads to postoperative bleeding risk

Annual Cost Estimate Snapshot: Thromboembolic management for AF patients

Cost Category	Annual Cost Range (per person)	What it represents
Chronic oral anticoagulation: Generic dabigatran	$480 – $800/year[13,14]	Ongoing outpatient anticoagulant therapy: generic dabigatran 150 mg BID[15]
Chronic oral anticoagulation: FXa-targeted DOACs (class-level)	~$3,000 – $4,500/year	Ongoing outpatient anticoagulant therapy (e.g., apixaban (5 mg BID)/rivaroxaban (15-20 mg once daily, taken with food) class use in Medicare Part D)[16,17]
Chronic oral anticoagulation: warfarin (drug only)	~$50 – $300/year	Generic warfarin tablets (patient-specific dosages determined in clinic)[18]

Cost Category	Annual Cost Range (per person)	What it represents
Warfarin total management (excluding drug cost)	~$600 – $4,000/year	INR testing, clinician follow-up, anticoagulation management[14,19]
Potentially avoidable bleeding hospitalization (GI bleed)	~$32,000/admission[20]	Inpatient admission for severe GI bleeding

Opportunity For Safer, Smarter Care

A **single severe GI bleed hospitalization (~$32K)** can exceed the cost of **an entire year of DOAC therapy** for many Medicare patients[2,20]. This is not a reason to avoid anticoagulation when it is indicated. It highlights why **indication confirmation, appropriate anticoagulant selection, renal/weight-based dosing, interaction review, duration (re)assessment, and safer transitions of care** matter—because they protect patients and reduce avoidable utilization and bleeding-associated hospitalization.

2. INDICATIONS AND CONTRAINDICATIONS

Indications

This Quick Reference Guide applies primarily to **older adults (>65)** at **high venous thromboembolic risk** and/or are in **hypercoagulable states** receiving long-term (**outpatient**) anticoagulation therapies for one of the following primary indications:

A. Atrial Fibrillation (AF)

Stroke prevention in patients meeting guideline-supported risk thresholds.[8,21]
Typical therapies:

- DOACs (preferred in most **nonvalvular AF; NVAF**)
- Warfarin (mechanical valves, moderate-to-severe mitral stenosis)
- LMWH (temporary inpatient anticoagulation or peri-procedural bridging in select patients)

B. Prior Venous Thromboembolism (VTE/PE)

Including the acute treatment phase, extended secondary prevention, and/or post–pulmonary embolism.[3,4]
Typical therapies:

- DOACs (first-line therapy) • Warfarin • LMWH (malignancy, pregnancy, selected high-risk patients)

C. Special Populations

- Cancer-associated thrombosis (**unprovoked VTE**) • Advanced CDK • Mechanical heart valves
- **Antiphospholipid syndrome** • Factor V Leiden or Protein C/S Deficiency syndromes
- Critically ill, sedentary hospitalized patients • Post-orthopedic surgery

Within each indication group, therapy choice must reflect patient-specific contraindications and safety considerations

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