Notify Patients That Brand-Name Coumadin Is Discontinued

The discontinuation of brand-name *Coumadin* will put the spotlight on avoiding mishaps with warfarin.

The manufacturer of *Coumadin* stopped making it in August due to manufacturing issues...NOT because of safety or efficacy problems.

Feel comfortable dispensing any *Coumadin* you have in stock.

But when your pharmacy and supplier run out, that's it.

Patients will need to switch to generic warfarin...or a different blood thinner (*Eliquis*, *Xarelto*, etc).

Help make this transition smooth for your team and patients.

Inform affected patients that *Coumadin* is no longer being made...and explain how you can help them prepare for the switch.

For example, your pharmacy may need to get a new Rx from the prescriber for generic warfarin...if the original *Coumadin* Rx specified "do not substitute."

If not, still notify prescribers of the change. Some may want to do closer lab monitoring after a switch.

Use this as a reminder to take extra care when dispensing warfarin. It's a "high-alert" med...and errors can be harmful or even fatal.

Watch decimal points closely. Mistaking warfarin 1.0 mg for warfarin 10 mg is a 10-fold dosing error...and could be lethal.

Apply a "Generic equivalent" auxiliary label when patients switch from brand-name *Coumadin* to generic warfarin. This helps notify patients that it works the same as the brand.

Listen for patients who might still have *Coumadin* at home...doubling up with generic warfarin may cause dangerous bleeding.

For more ways to keep patients on warfarin or other anticoagulants safe, see our technician tutorial, *Dispensing Oral Blood Thinners*.

Key References:

-Aust Med Stud J 2016;7(1):22-8
-Aust Prescr 2015;38(5):150-1
-www.bms.com/assets/bms/ca/documents/productmonograph/CANADA-Coumadin-deletion_D-HCP-Communication_FINAL_EN_04.23.2020.pdf (8-28-20)

Pharmacy Technician's Letter Canada. September 2020, No. 360910