SY Integrated Medicines Optimisation Committee

Shared Care Protocol for the prescription and supply of Enoxaparin

for patients aged 16 years and older

Version 1

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Version history

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1. Quick Reference to the Sheffield Shared Care Protocol for Enoxaparin

	Treatment of VTE	Prophylaxis of VTE
Patients included (≥16 years old)	Selected patients with VTE (some cancer patients, those unstable on, unsuitable for, or with a contra-indication to oral anticoagulants, those with recurrent VTE whilst on oral anticoagulant, injectable drug users). Pregnant women with VTE	High-risk surgical patients, those with a history of thrombosis associated with central venous access, certain cancer patients, pregnant women at high-risk of VTE & for management of the antiphospholipid syndrome (recurrent miscarriage/ adverse pregnancy outcome)
Dosage & duration of therapy (see below for doses in renal impairment)	**Pregnant and post-partum women where CrCl ≥ 30mL/min** Dose based on renal function and early booking weight: **Initial dose:** < 50kg: 40mg BD 50 – 69kg: 60mg BD 70 – 89kg: 80mg BD 90 – 109kg: 100mg BD 110 – 125kg: 120mg BD >125kg: 1mg/kg BD (rounded to the nearest syringe) **Ongoing -** may be prescribed as once daily in patients weighing ≤125kg following review by a Thrombosis Nurse/ Haematologist: **Ongoing dose** <50kg: 60mg OD 50 – 69kg: 100mg OD 70 – 89kg: 120mg OD 90 – 109kg: 150mg OD 110 – 125kg: 180mg OD >125kg: continue 1mg/kg BD (rounded to nearest syringe) Continued throughout pregnancy & for at least 6 weeks post-partum as advised by Haem/Obs clinic **All other patients:** where **CrCl ≥ 30mL/min** Dose based on indication, weight and renal function (CrCl) Dose for **high-risk patients** (those with body weight ≥ 126kg, recurrence or extension of VTE whilst on anticoagulation, symptomatic pulmonary emboli, antiphospholipid syndrome, luminal cancers who are at high risk of bleeding) **1mg/kg BD**. ≤ 47kg: 40mg BD 48 – 73kg: 60mg BD 74 – 88kg: 80mg BD 89 – 109kg: 100mg BD 110 – 130kg: 120mg BD 131 – 159kg: 150mg BD 160 – 199kg: 180mg BD 200+ kg: discuss with haematology May be reduced after 5-10 days to once daily (see below). Continue for 3-6 months if 1st event; long-term if recurrent idiopathic event; consider using long-term if ongoing risk factor **Standard dose (1.5mg/kg OD**): ≤47kg: 60mg OD 48 – 59kg: 80mg OD 60 – 73kg: 100mg OD 74 – 88kg: 120mg OD 89 – 99kg: 150mg OD 100 – 125kg: 180mg OD	**In pregnancy for those at risk:** Dose based on renal function and early booking weight. Weight used should not change: **eGFR ≥ 30 ml/min/1.73m²:** < 50kg: 20mg OD 50 - 90kg: 40mg OD 91-130kg: 60mg OD 131-170kg: 80mg OD >170kg: 0.6mg/kg/day in 2 divided doses Rounded to nearest syringe Continued throughout pregnancy and for 6 weeks postpartum. May be stopped at term in antiphospholipid syndrome associated with recurrent miscarriages. Note: women with previous recurrent VTE or previous VTE associated with high-risk antithrombin deficiency or antiphospholipid syndrome require higher doses of LMWH for thromboprophylaxis and will receive enoxaparin at 50%, 75% or full treatment dose. **All other patients:** Dose based on weight and renal function (eGFR ml/min/1.73m²): **eGFR ≥ 30ml/min/1.73m²:** ≤44kg: 20mg OD 45-99kg: 40mg OD 100-149kg: 40mg BD ≥150kg: 60mg BD High-risk surgical patients usually receive a 28-day course post-operatively or post-discharge. Patients who have surgery to repair a fractured neck of femur receive a 28-day course post-operatively. Other at-risk patients (e.g. bariatric or vascular surgery) may receive 7-10 days post-discharge. Therapy continued for duration of increased risk for other patients e.g. as long as central line is in-situ

<table>
<tr><td>Renal Impairment</td><td><u>Pregnant and postpartum women where CrCl < 30 mL/min</u>
Discuss with haematology

<u>All other patients where CrCl 15-29 mL/min use 1mg/kg OD</u>
≤ 48kg: 40mg OD
48 – 73kg: 60mg OD
74 – 88kg: 80mg OD
89 – 109kg: 100mg OD
110 – 130kg: 120mg OD
131 – 159kg: 150mg OD
160 – 199kg: 180mg OD
200 + kg: discussed with haematology

Contraindicated in CrCl < 15 mL/min or in patients on haemodialysis</td><td><u>Pregnancy</u>
eGFR < 30ml/min/1.73m^2
all weights: 40mg OD and monitor anti-Xa levels, in discussion with haematology

<u>All other patients</u>

eGFR 15 – 29ml/min/1.73m^2:
up to 99kg: 20mg OD
100 – 149kg: 40mg OD
150kg & above: 60mg OD

eGFR < 15ml/min/1.73m^2 or on haemodialysis:
all weight: 20mg OD</td></tr>
<tr><td>Hospital supply</td><td colspan="2">First 28 days of prophylaxis or therapeutic dose (high-risk surgical patients receive the total course from hospital)</td></tr>
<tr><td>Secondary care monitoring</td><td colspan="2">Baseline FBC, coagulation screen (for treatment doses only), U&E, LFT*.
Measurement and documentation of body weight at initiation of treatment.

Repeat FBC within 24hrs and every 2-3 days for the first 14 days of receiving LMWH, ONLY in patients who have had cardiopulmonary bypass or any surgical procedure and exposure to heparin/LMWH in the previous 100 days.
Regular potassium levels in patients at risk of hyperkalaemia i.e. those with diabetes mellitus, chronic renal failure, acidosis, raised potassium levels, on potassium-sparing drugs or potassium supplements or on long-term enoxaparin treatment.

*Baseline blood tests are not required in otherwise healthy pregnant and postpartum women on LMWH for extended prophylaxis</td></tr>
<tr><td>Primary care monitoring</td><td colspan="2">Regular potassium monitoring in high-risk patients i.e. those with diabetes mellitus, chronic renal failure, acidosis, raised potassium levels, on potassium-sparing drugs or potassium supplements or on long-term enoxaparin treatment).
Patients weight – adjust enoxaparin dose as above if weight alters, except during pregnancy.
Monitor renal function – dose may need adjusting if renal function deteriorates.</td></tr>
</table>

Patients/ carers will be taught to administer; otherwise a referral will be made for administration by the Community Nursing team.

GPs will not be asked to initiate therapy;
requests for shared care will be made via the Enoxaparin Shared Care Form

Background and supporting information

The use of low molecular weight heparins (LMWH) to prevent and treat venous thromboembolism (VTE) has increased significantly in recent years. The availability of LMWHs has permitted the treatment of VTE on an outpatient basis, and NICE guidelines concerning the prevention of VTE have led to an increase in the use of prophylactic LMWH. LMWHs are now widely used for a number of licensed and unlicensed indications.

Choice of LMWH
From September 2026, patients at Doncaster and Bassetlaw Teaching Hospitals will be initiated on the enoxaparin preparation, Clexane®. This SCP uses the generic name enoxaparin throughout. However, **prescribing by brand is essential in primary care** to ensure continuity of supply to the patient who will have been trained in administration of this device.

Purpose of the shared care protocol
This shared care arrangement has been developed to facilitate the prescribing and supply of LMWHs in the community and to provide a reference source for those involved in prescribing, supplying and monitoring patients who need LMWH, for treatment or prevention of VTE.

Exclusions from the shared care protocol
Patients with the following conditions are excluded from this guideline:

- History of Heparin Induced Thrombocytopenia (HIT)
- Significant hepatic impairment
- Active gastric or duodenal ulceration or oesophageal varices
- Haemophilia and other inherited bleeding disorders / major bleeding disorders
- Thrombocytopenia with platelets less than $75x10^9$/L
- Recent cerebral haemorrhage
- Severe hypertension (i.e. 230/120mmHg or higher)
- Recent neurosurgery or eye surgery
- Acute bacterial endocarditis
- Hypersensitivity to heparin, enoxaparin or other low molecular weight heparins
- Peri-procedural bridging anticoagulation
- Children under 16 years

Administration of enoxaparin
In most circumstances the patient or carer is advised on how to perform the administration of enoxaparin. If this is not possible a referral is made to the community nursing team to administer the injection.

Clinic Review
The medical team initiating treatment or prophylaxis is responsible, where required, for ensuring that the patient attends for regular disease review at intervals determined by their clinical status. This would normally be carried out by that medical team. If haematology input is desired, the GP or medical team must make a referral to one of the consultant haematologists at DBTH.

Contacts
If any problems or concerns arise, please contact the relevant specialist:
Consultant initiating enoxaparin treatment (contact details on referral form / clinic letters)

Summary of Responsibilities

Responsibilities of the specialist

- Initiate treatment with enoxaparin and provide the first 28-days of treatment, or the whole course for high-risk surgical patients needing extended thromboprophylaxis post-operatively
- Instruct patient or carer on administration (or arrange for community nursing team to administer where this is not possible)
- Ensure patient has been given adequate written and verbal information about what enoxaparin is, why it is being used, awareness of side effects, what to do if the side-effects occur and what the arrangements are for further prescriptions
- Monitor for heparin-induced thrombocytopenia and/or hyperkalaemia during the first 14 days of treatment-dose enoxaparin where necessary – see here for details.
- Make formal referral to primary care provider using the Enoxaparin Shared Care Form
- Keep the patient under clinical review by the consultant initiating enoxaparin, assessing need for ongoing enoxaparin treatment for up to 6 months or arranging referral to consultant haematologist to assess need for longer-term treatment
- Provide advice and support if problems occur during treatment
- Give written direction to the GP as to when treatment should be discontinued
- Conduct annual audit / review as deemed appropriate

Responsibilities of Primary Care

- Accept referral from secondary care to take on continued prescribing of enoxaparin under this shared care agreement after initial 28 days (or sooner if agreed).
- Be aware that there are a number of different preparations of enoxaparin injection; **only pre-filled syringes of the brand Clexane®** should be prescribed under the terms of this shared care protocol.
- Reinforce educational points provided by the hospital.
- Monitor for hyperkalaemia in those patients at higher risk of raised plasma-potassium concentrations (those with diabetes mellitus, chronic renal failure, acidosis, raised potassium concentrations, those taking potassium-sparing drugs / potassium supplements or patients on long-term treatment). Monitoring U/Es should be done up to 3 monthly in these patients and according to clinical judgment.
- **Re-weigh non-pregnant patients on long-term enoxaparin at a frequency according to clinical judgement** e.g. more often if rapid weight loss (e.g. cancer patients) **and change weight-adjusted doses as appropriate** (see appendix 1).
- Monitor renal function and seek advice if deterioration becomes evident.
- Keep records or a register (using appropriate Snomed codes) of all patients for whom enoxaparin has been prescribed. Records should include relevant details such as indication, concurrent conditions, dose, start date, expected duration, monitoring details, adverse incidents, consultants involved in treatment, any advice or actions.
- Discontinue treatment if the patient experiences severe side effects and the relevant contact at the hospital is not available.
- Confirmation letter to patient and/or carer if treatment is discontinued.
- Conduct audit / annual review as deemed appropriate.

Enoxaparin for Treatment of VTE disease

The categories of patient suitable for primary care continuation of prescription of enoxaparin for treatment of VTE disease are as follows**:**

- Patients with a contra-indication to oral anticoagulants
- Patients in whom it has not been possible to stabilise on oral anticoagulant therapy
- Some patients with recurrent VTE whilst on oral anticoagulant
- Pregnant patients with VTE disease

Such patients who are referred to primary care providers under the shared care arrangements will have been prescribed enoxaparin for more than 28 days by a secondary care specialist. Where it is necessary, arrangements for monitoring for heparin induced thrombocytopenia (HIT) will usually have been completed before referral to primary care.

Initial prescription & monitoring
A decision is made for a patient to be commenced on enoxaparin by the patient's clinical team following discussion with the patient. Baseline investigations will be undertaken, and, if satisfactory, the patient will be commenced on treatment. At discharge, the patient will be given a prescription for a 28-day supply of the drug. Monitoring for heparin induced thrombocytopenia (HIT) will only be necessary in patients who have had cardiopulmonary bypass or any surgical procedure and exposure to heparin/LMWH in the previous 100 days. They should have their full blood count (FBC) monitored every 2-3 days for the first 14 days of receiving enoxaparin. If the platelet count falls by 30% or more, OR symptoms of thrombosis develop, contact the on-call haematologist for advice. Patients requiring HIT monitoring after discharge should be referred to hospital-based anticoagulation clinic for this to be completed. The patient's GP will be informed of the proposed management plan and monitoring arrangements.

Referral method from secondary to primary care for continuation of supply
A formal referral to the patient's GP will be made from the DBTH medical team initiating enoxaparin treatment using the Enoxaparin Shared Care Form. If HIT monitoring is necessary and has not been completed, the patient will be referred to the anticoagulant clinic for monitoring.

At the point of transfer, a medical and medication history will be provided to the GP, including:

- Consultant and contact details
- Indication for enoxaparin, dose prescribed & proposed duration of treatment, including intended dose changes if applicable
- Patients weight, baseline creatinine, platelet and potassium results
- Date treatment started
- Other relevant clinical information, including concurrent medication
- Interval before patient next due to be seen by DBTH for disease review
- Any specific instructions for the practice, e.g. for continued monitoring of potassium

Treatment should only be discontinued prematurely by the primary care clinician after discussion with the responsible hospital clinician, unless there are exceptional circumstances. Treatment discontinuation must be confirmed by letter from the GP practice to the hospital clinician and patient and/or carer.

Primary care monitoring
Once the patient has been accepted by their primary care provider the responsibility for re-prescribing the drug and further monitoring of renal function and for hyperkalaemia, if appropriate, will pass to the patient's practice (see "Responsibilities of Primary Care"). This will be communicated via the enoxaparin shared care form. It is advised that this monitoring is done regularly up to 3 monthly and according to clinical judgment, and action taken as appropriate. **Since the dose of enoxaparin for treatment of VTE is calculated based on weight, non-pregnant patients on long-term therapy should be re-weighed** (at a frequency determined by clinical judgement e.g. more often if rapid weight loss) **and the dosage of enoxaparin adjusted accordingly** see appendix 1).

Enoxaparin for Prophylaxis of VTE disease

The patients who may be discharged from secondary care on thromboprophylaxis with enoxaparin are:

- High risk surgical patients requiring extended prophylaxis according to NICE and DBTH guidelines
- Those with a history of thrombosis associated with central venous access lines
- Pregnant women requiring prophylaxis
- Cancer patients undergoing cancer therapies or with metastatic malignancies

High risk surgical patients discharged on extended thromboprophylaxis:
Prescription & monitoring
All high risk surgical patients who need extended thromboprophylaxis following discharge will be given sufficient enoxaparin on the discharge prescription to complete the full course of prophylaxis.
Monitoring for heparin induced thrombocytopenia (HIT) will only be necessary in patients who have had cardiopulmonary bypass or any surgical procedure and exposure to heparin/LMWH in the previous 100 days. They should have their full blood count (FBC) monitored every 2-3 days for the first 14 days of receiving enoxaparin. If the platelet count falls by 30% or more, OR symptoms of thrombosis develop, contact the on-call haematologist for advice. Patients requiring HIT monitoring after discharge should be referred to hospital-based anticoagulation clinic for this to be completed.

Other patients on prophylactic enoxaparin:
Initial prescription & monitoring
Other patients than those above will be given a 28-day supply of prophylactic enoxaparin by the DBTH clinical team responsible for their care. Where it is necessary arrangements will be made for monitoring for heparin induced thrombocytopenia to be performed by the DBTH Anticoagulation Clinic. The patient's GP will be informed of the proposed management plan and monitoring arrangements.

Referral method from secondary to primary care for continuation of supply
A formal referral to the patient's GP will be made from the DBTH medical team initiating enoxaparin treatment using the Enoxaparin Shared Care Form. A full history of the patient will be provided, including:

- Name of responsible consultant and contact details
- Indication for enoxaparin, dose prescribed & proposed duration of treatment, including intended dose changes if applicable
- Date treatment started
- Other relevant clinical information, including concurrent medication
- Baseline creatinine, platelet and potassium results
- Interval before patient next due to be seen by DBTH for disease review
- Any specific instructions for the practice, e.g. for continued monitoring of potassium

Treatment should only be discontinued by the primary care clinician after discussion with the responsible hospital clinician, unless there are exceptional circumstances. Treatment discontinuation must be confirmed by letter from the GP practice to the hospital clinician and patient and/or carer.

Primary Care monitoring
Once the patient has been accepted by their primary care provider the responsibility for re-prescribing the drug and further monitoring of renal function & for hyperkalaemia (if appropriate, see "Responsibilities of Primary Care"), will pass to the patient's practice. This will be communicated via the enoxaparin transfer form. It is advised that this monitoring is done regularly, according to clinical judgment.

References

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2. Thromboembolic Disease in Pregnancy and the Puerperium: Acute Management. Royal College of Obstetricians and Gynaecologists Green Top Guideline No 37b April 2015 https://www.rcog.org.uk/globalassets/documents/guidelines/gtg-37b.pdf

3. American Society of Clinical Oncology Guideline: Venous thromboembolism; Prophylaxis and treatment in patients with cancer. Key N S et al. J Clin Oncol 41 2023 Venous Thromboembolism Prophylaxis and Treatment in Patients With Cancer: ASCO Guideline Update | Journal of Clinical Oncology

4. Low molecular weight heparin for intravenous drug users with deep vein thrombosis. Michael Russell and Deborah Dawson. http://emj.bmj.com/content/21/6/711.1.full

5. Summary of Product Characteristics enoxaparin (Inhixa): https://www.medicines.org.uk/emc/search?q=inhixa

6. STH Thromboprophylaxis Guidelines http://nww.sth.nhs.uk/STHcontDocs/STH_CGP/Haematology/PreventionOfVenousThromboembolicDiseaseGuidelines.doc

7. NICE Guideline 89: Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism, Mar 2018, last updated Aug 2019 https://www.nice.org.uk/guidance/ng89

8. DH 2010. EFA2010/001 Medical patient weighing scales https://www.cas.mhra.gov.uk/ViewandAcknowledgment/ViewAlert.aspx?AlertID=101365

9. Guidelines on the diagnosis and management of heparin-induced thrombocytopenia: Third Edition. Deepa J. Arachchillage, Jecko Thachil, Julia A. M. Anderson, Peter Baker, Anthony Poles, Steve Kitchen, Mike Laffan, British Journal of Haematology 2024, 204 : 459 – 475 https://doi.org/10.1111/bjh.19180

10. Investigation and Treatment of Venous Thromboembolic Disease [Deep Vein Thrombosis (DVT) and Pulmonary Embolism (PE)] April 2022 http://nww.sth.nhs.uk/STHcontDocs/STH_CGP/Haematology/ThromboembolicGuideline.doc

11. STH Guideline on Thromboprophylaxis in Pregnancy and the Puerperium Oct 2022 http://nww.sth.nhs.uk/STHcontDocs/STH_CGP/Obstetrics/Thromboprophylaxis.doc

Version history

This SCP for enoxaparin has been developed from the Shared Care Guideline between Sheffield Teaching Hospitals NHS Foundation Trust and NHS Sheffield Clinical Commissioning Group for the prescription and supply of Dalteparin (Fragmin®) and updated for use in Doncaster in September 2026

Appendix 1: Relevant Links

The Summary of Product Characteristics documents for enoxaparin can be found at:
https://www.medicines.org.uk/emc/search?q=clexane

Enoxaparin Dosing Tables (link to Doncaster formulary page)
https://www.dbth.nhs.uk/wp-content/uploads/2026/09/VTE-Prophylaxis-Guidance-Enoxaparin-Sept-26-New.pdf

Licensed indications included in this shared care protocol

- Prophylaxis of venous thrombosis in surgical and orthopaedic patients
- Prophylaxis of venous thrombosis in medical patients who are bedridden due to acute illness
- Treatment of venous thromboembolism (deep vein thrombosis and pulmonary embolism) until oral anticoagulant treatment has been initiated and is therapeutic
- Treatment of deep vein thrombosis or pulmonary embolism in patients with cancer

Unlicensed indications included in this shared care protocol

- In pregnancy for the prevention and treatment of venous thrombosis in pregnancy, and for treatment of the antiphospholipid syndrome
- Treatment of deep vein thrombosis or pulmonary embolism in those in whom it has not been possible to stabilise oral anticoagulants or in whom oral anticoagulants are thought to be unsuitable.
- Prophylaxis if thrombosis associated with central lines

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

ENOXAPARIN (Clexane®) SHARED CARE FORM

For all patients requiring ongoing enoxaparin therapy: email this referral to GP for ongoing prescription according to the Enoxaparin Shared Care Protocol

Hospital to provide initial 28-day supply of enoxaparin and to undertake heparin-induced thrombocytopenia (HIT) monitoring if required.

Patient's medical care remains with the hospital consultant who initiated enoxaparin. GP to continue prescribing and carry out further monitoring as appropriate.

Name:

DoB:

Affix patient label here

Hosp No.:
NHS No.:
Consultant:

1) REFERRING CONSULTANT DETAILS

Referring consultant:_____ DRI [ ] BDGH [ ]

Consultant email address:_____

Next consultant clinic appointment date: _____ GP/practice receiving referral:_____

2) INDICATION FOR ENOXPARIN

a) Thromboprophylaxis: In pregnancy □ Central line □ Cancer □

b) Deep vein thrombosis/ Pulmonary embolism: In pregnancy □ Injectable drug user □

Associated with cancer/ cancer therapies □ Unsuitable for oral anticoagulation □

3) TREATMENT INFORMATION

Patient's weight_____ (kg) Dose of enoxaparin_____ mg ONCE/TWICE daily (delete as appropriate)

Date started _____

Intended dose changes (if applicable):
Dose to change to _____ units ONCE/TWICE daily (delete as appropriate) on (date) _____

Proposed duration of treatment:
3 months □ 6 months □ LIFELONG □ DURATION OF PREGNANCY □
Enoxaparin to be administered by: Patient or carer □ District Nurse (send this form along with DN referral) □

4) MONITORING REQUIREMENTS

Baseline results
Creatinine:_____(µmol/L) Creatinine clearance:_____(mls/min) Platelets:_____(x10^9/L) Potassium:_____(mmol/L)

FORM COMPLETED BY:
Signature: _____ Print name: _____

Designation: _____ Contact No.(bleep/ext.): _____ Date: _____

Emailed to: _____ **GP/ Practice** at Time: _____ Date: _____

By: _____ Time: _____ Date: _____

PRIMARY CARE TO COMPLETE:
I _____ (*insert name of primary care clinician*) can confirm I:

□ **Accept** the request to participate in shared care for the patient named above and will complete the monitoring as set out in the cared care protocol for this medicine/ condition
□ **Reject** the request to participate in shared care; the reason for this being (*optional)*……

Signature of primary care clinician (Doctor/ Nurse/ Other)**:** _____ Date: _____

GP/ practice receiving referral: _____ **Emailed by**: _____ Date: _____