Table 3. Dosage adjustments for patients on warfarin maintenance therapy (Target INR 2.0 – 3.0 or 2.5 or 3.5, No significant bleeding)

INR	**Intervention** – Refer to Figure 1 for timing of next INR
< 1.5	Give one time top-up equal to 20% of weekly dose and increase weekly dose by 10 – 20%.
1.5 < INR < therapeutic range	No change in dose. If two consecutive INRs are low, increase weekly dose by 10 – 20%.
INR in therapeutic range	No change.
INR > therapeutic range but < 5.0	Lower weekly dose (10 – 20%) or consider omitting one single dose. Increase the frequency of INR monitoring and resume therapy at 10 – 20% lower weekly dose when INR therapeutic. Note: If the INR is only minimally elevated (0.1 – 0.4 above upper limit of the therapeutic range), dose reduction may not be necessary.[25]
INR 5.0 – 9.0*	Omit 1-2 doses then recheck INR. Increase the frequency of INR monitoring and resume therapy at 10 – 20% lower weekly dose when INR therapeutic. If the patient is at high risk of serious bleeding, consider administering vitamin K** 1 – 2 mg orally.
> 9.0 no bleeding	Discontinue warfarin temporarily, consider administering vitamin K 2 – 5 mg orally then recheck INR.*** Increase the frequency of INR monitoring and resume therapy at 20% lower weekly dose when INR therapeutic. Give additional vitamin K if INR is not substantially reduced by 24 hours.***

Abbreviation: INR = international normalized ratio.
Footnotes: * Bleeding risk increases exponentially from INR 5 to 9[26] and should be monitored closely. ** If vitamin K is not available in your local pharmacy, it can be obtained from your local emergency department. Avoid intramuscular injections of vitamin K to prevent local injection site bleeding which also reduces bioavailability. *** The effect of a single dose of vitamin K on the INR can be expected between 8-24 hours.

Source: https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines/warfarin-therapy