Prasugrel (EFFIENT)
Criteria for Use
October 2025

VA Pharmacy Benefits Management Services, Medical Advisory Panel, and VISN Pharmacist Executives

The following recommendations are based on medical evidence, clinician input, and expert opinion. The content of the document is dynamic and will be revised as new information becomes available. The purpose of this document is to assist practitioners in clinical decision-making, to standardize and improve the quality of patient care, and to promote cost-effective drug prescribing. THE CLINICIAN SHOULD USE THIS GUIDANCE AND INTERPRET IT IN THE CLINICAL CONTEXT OF THE INDIVIDUAL PATIENT. INDIVIDUAL CASES THAT ARE EXCEPTIONS TO THE EXCLUSION AND INCLUSION CRITERIA SHOULD BE ADJUDICATED AT THE LOCAL FACILITY ACCORDING TO THE POLICY AND PROCEDURES OF ITS P&T COMMITTEE AND PHARMACY SERVICES.

The Product Information should be consulted for detailed prescribing information.

Exclusion Criteria

If the answer to ANY item below is met, then the patient should NOT receive prasugrel.

- ☐ Active pathologic bleeding
- ☐ Clinically important anemia or thrombocytopenia
- ☐ History of prior transient ischemic attack (TIA), stroke, or intracranial hemorrhage (ICH)
- ☐ Body weight less than 60 kg[1]
- ☐ Age 75 or older unless at high risk of ischemic events (e.g., diabetes mellitus or prior myocardial infarction) and otherwise low bleeding risk[1]
- ☐ Planned or recent fibrinolytic therapy (e.g., within past 24 hours)
- ☐ Concomitant anticoagulant therapy (clopidogrel is preferred $P2Y_{12}$ inhibitor for use in combination with an oral anticoagulant)[2]
- ☐ Severe hepatic impairment
- ☐ Anticipated urgent coronary artery bypass graft (CABG) surgery (e.g., within 7 days)

Inclusion Criteria

The answer to one of the following must be fulfilled in order to meet criteria.

- ☐ ST-elevation myocardial infarction acute coronary syndrome (STEMI-ACS) and undergoing PCI
- ☐ Non-ST elevation ACS with planned PCI after coronary anatomy identified and deemed suitable for PCI, ischemic symptoms lasting ≥10 min and occurring within 72 hrs of presentation, TIMI risk score of ≥3, and either ST segment deviation of ≥1 mm or positive cardiac biomarkers[3]
- ☐ Definite or probable acute stent thrombosis (Academic Research Consortium definition) in patients documented to be compliant with aspirin and clopidogrel
- ☐ Reduced clopidogrel response (e.g., any documented CYP2C19 intermediate or poor metabolizer phenotypes or high on-treatment platelet reactivity by $P2Y_{12}$ reaction units [PRU] testing) and continued indication for $P2Y_{12}$ inhibitor therapy[4]
- ☐ Extended duration dual antiplatelet therapy (DAPT=aspirin plus $P2Y_{12}$ inhibitor) beyond 12 months following an ACS event as per Cardiology re-evaluation
- ☐ Undergoing PCI with or without ACS in patients with clopidogrel allergy or true aspirin allergy

[1]If no other antiplatelet is appropriate (e.g., allergy, contraindication, etc.), standard dose prasugrel may be considered but is associated with no net clinical benefit in patients 75 and older or who weigh less than 60 kg. Alternatively, the lower dose of 5 mg of prasugrel daily may be considered but has not been as rigorously studied.

[2]Ticagrelor may be an alternative in high thrombotic/acceptable bleed risk; prasugrel is not recommended due to limited data and increased bleeding risk.

[3]Thrombolysis in Myocardial Infarction (TIMI) Risk Score (one point each): age ≥65; ≥3 coronary artery disease (CAD) risk factors; known CAD with >50% stenosis; aspirin use in past 7 days; severe angina within preceding 24 hrs, elevated cardiac marker.

[4] If prior pharmacogenomic test results are available, the results should be reviewed and added to the decision-making process.

Supplemental Information

- **Extended durations of therapy:** DAPT for at least 12 months is guideline recommended therapy after ACS; longer or shorter durations may be considered with the understanding that DAPT reduces ischemic risk but increases bleeding risk. The optimal $P2Y_{12}$ antagonist for extended treatment is unclear due to lack of head-to-head data. In ACS populations, the risk of bleeding with clopidogrel is typically lower than prasugrel or ticagrelor.
- **Reduced clopidogrel response:** In total, evidence suggests that patients with known CYP2C19 intermediate or poor metabolizer phenotypes or high on-treatment platelet activity testing on clopidogrel are at increased risk of subsequent cardiovascular events. However, routine pharmacogenomic or platelet function screening is not currently guideline recommended, and the ultimate clinical benefit of a guided-use strategy is unknown.

Prepared August 2021 (Revised Nov 2023, Oct 2025). Contact: Lisa Longo, Pharm.D., BCPS, National Clinical Pharmacy Program Manager, VA Pharmacy Benefits Management Services (12PBM)