INTRAMED Plus
infusion services

CATHFLO® ACTIVASE®

INFUSION & MEDICAL CENTER

1. _____ _____ _____

Patient Name **DOB** **Patient Phone/Cell #**

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Venous Access Device Information:

Access Type: _____ # Lumens: 1 2 3

Insertion Date: _____

Patient
Weight: _____ lbs.
Height: _____ in.

Cathflo® Activase® (alteplase)

3. Drug Order:

Cathflo® Activase® (alteplase) 2 mg
Instill 2 mg in each lumen (_____ lumens) per established policy and procedure.
If catheter function is not restored within 120 minutes after first administration, instill a second dose per established policy and procedure.

Sodium Chloride 0.9% 10 mL flushes
PRN as per established policies and procedures

Heparin 100 units/mL 5 mL flushes
PRN as per established policies and procedures

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus
to serve as my prior authorization agent with medical and pharmacy insurance providers.

4. Physician Signature: _____ / _____ Date: _____

Dispense as written Substitution permitted

Printed Physician's Name:_____Contact Phone #: _____

FAX ALL INFORMATION	INFUSION CENTER LOCATIONS
CENTRAL FAX **803.999.1754**	**COLUMBIA CHARLESTON GREENVILLE** **CENTRAL INTAKE PHONE 803.999.1760**

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