

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 CENTRAL FAX 803.999.1754 ALTERNATE FAX 803.999.1887	INFUSION CENTER LOCATIONS COLUMBIA CHARLESTON GREENVILLE CENTRAL INTAKE PHONE 803.999.1960
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