Referral Status:		MRN:
☐ New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:		

Cathflo® Activase® (alteplase) Standard Plan of Treatment for Line Care

PATIENT DEMOGRAPHICS:								
Date of Referral:				Patient's Phone:				
Patient Name:				Address:				
Date of Birth:				City, State, Zip:				
Height in inches:	Weight:	LB or	KG	Gender:	Allergies:	☐	See list	☐ NDKA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐ _____ - Other:

☐ _____ - Other:

REQUESTED DOCUMENTATION:		PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?	
1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INJECTION DATE:
3	Full medication list		NEXT INJECTION DATE:
4			**IF ORDER CHANGE:**
5			☐ **Continue current order until insurance approved**
6			

MEDICATION ORDERS:

MEDICATION/DOSE:

☑ Cathflo® Activase® (alteplase) 2mg intracatheter, x ____ lumen(s).
Instill alteplase for no blood return, occluded line, or sluggish flush. After 30 minutes of dwell time, reassess catheter patency by aspirating blood return. If catheter function is not restored after 120 minutes of dwell time, then a second dose may be instilled. **Patients weighing less than 30 kg require adjusted dosing.**

Catheter Specific Orders:

☑ Change dressing and cap(s) as required per protocol. If catheter function is restored, aspirate 4-5 ml of blood in patients greater than or equal to 10 kg or 3 ml in patients less than 10 kg to remove Cathflo® Activase® (alteplase) and residual clot. Flush line with 5-20ml of Sodium Chloride 0.9% IV per line type as required. Then flush with Heparin 100 units/ml IV per line type as required or **Heparin 10 units/ml IV 1-5ml per line type as required (for pediatric patients).** Notify referring physician if patency is not established and further clinical evaluation is required.

SPECIAL ORDERS:

☐ _____

LINE USE/CARE ORDERS:	ADVERSE REACTION & ANAPHYLAXIS ORDERS:
☑ Start PIV/Access CVC ☑ Flush device per facility standard flushing procedure	Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:	
PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE
Dispense as written/Brand medically necessary	Substitution permitted	

Palmetto
INFUSION

Checklist for referrals to Palmetto Infusion:

Fax referral to 1.866.872.8920

- ☐ **Patient demographics – address, phone number, SS#, etc.**
- ☐ **Insurance Information – copy of the card(s) if possible**
- ☐ **Plan of Treatment/Orders**
- ☐ **Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs.**
- ☐ **Any lab results or other diagnostic procedures to support the diagnosis**

Palmetto Infusion will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility.

Our office will notify you if any further information is required.

We will review financial responsibility with the patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for the referral.

www.PalmettoInfusion.com

02/10/2023