Transition to Tenecteplase Checklist

- ☐ Involve all stakeholders. This should include pharmacy, providers, stroke program leadership, and administration
- ☐ Determine if this is a feasible change for your facility--the decision to switch is determined by your facility and providers*
- ☐ Consider following the State recommendations on dosing of Tenecteplase in stroke
- ☐ Develop a Tenecteplase order set
- ☐ Update all current stroke protocols and resources
- ☐ Develop education/competency check off for nursing, pharmacy, and providers
- ☐ Develop process to safely differentiate stroke and MI Tenecteplase dosing
- ☐ Set a timeline (Do not be afraid to extend timeline to ensure safe transition)
- ☐ Develop education for patients

Transition Tips

- ✓ Consider making a full transition to Tenecteplase rather than alternating between Tenecteplase and Alteplase
- ✓ Medication safety is the priority--utilize Tenecteplase rather than TNK or TNKase to avoid confusion with tPA or TXA
- ✓ Do not underestimate the number of places Alteplase verbiage can be found
- ✓ Share updated acute stroke order set with telemedicine services
- ✓ Update dot phrases and downtime forms with new order sets and protocols
- ✓ Be mindful that Tenecteplase cannot be exchanged if premixed and not administered

*The transition to Tenecteplase is a facility specific choice. The North Dakota Stroke Task Force does not endorse the use of one thrombolytic over the other.

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STROKE LITERATURE

- Guidelines for the Early Management of Patients with Acute Ischemic Stroke: 2019 Update to the 2018 Guidelines for the Early Management of Acute Ischemic Stroke
- Tenecteplase Thrombolysis for Acute Ischemic Stroke

DOSING

Tenecteplase dose for **STROKE** is 0.25mg/kg (actual body weight) with a **MAXIMUM DOSE** of **25 mg**

- IV push over five seconds
- Not compatible with any dextrose containing solutions
- Flush IV with Normal Saline before and after Tenecteplase administration
- You will never administer a full vial to treat stroke
- The stroke dosage is NOT listed on the box

INCLUSION/EXCLUSION CRITERIA

Please refer to the ND Inclusion and Exclusion Criteria for IV Thrombolytic Treatment of Ischemic Stroke

COMPLICATIONS

- Oral Angioedema
- Hemorrhagic Transformation
- Systemic Bleeding

REVERSAL

If the patient experiences hemorrhage post-Tenecteplase administration, follow the 2019 AHA Clinical Practice Guidelines for reversal of thrombolytics:

- Cryoprecipitate 10 units IV infused over 10-30 minutes

If Cryoprecipitate is contraindicated or unavailable, administer:

- Tranexamic acid 1000 mg IV infused 10 minutes

OR

- Aminocaproic acid 4-5 g IV infused over 1 hour, followed by 1 g IV until bleeding is controlled

MONITORING

-Vital signs and neuro checks every 15 minutes x 2 hours, every 30 minutes x 6 hours, then hourly until 24 hours after treatment

-If blood pressure is greater than 180/105, notify provider

-Repeat head CT if neuro status declines

-NIHSS – Post administration and with any neuro changes

-No anticoagulant/antiplatelet for 24 hours

-Monitor for complications