

Best Practices

PROFILING AND TARGETING *(some of this may sound like common sense but it can be very effective)*

KNOW YOUR TERRITORY

- › How many accounts do you have in your territory? *(most likely there are between 30-50 that you should be calling on regularly)*
- › Of those accounts, how many of them are hospitals, as those are the accounts you need to target for Uni-Fuse. Almost every hospital you have in your territory stocks some type of side-hole catheter in either the IR, Cath Lab, OR and utilized in their ICU.
 - Notice the use of the term “side-hole catheter”, in some departments (or with some personnel) it may be the easier nomenclature to use.

Possible drill-down & probing questions you should be asking to begin a conversation about Thrombus Management, CDT as well as identifying your customer’s pain point...

- › How do you treat DVT?
- › Are you currently doing thrombolysis? If they say they’re doing thrombectomy instead, the follow up questions would be: *“When thrombectomy isn’t 100% effective, would you consider inserting a thrombolytic catheter to infuse a lytic agent to help further clear the vessel?”*
- › What type of thrombolytic or infusion catheter do you use?
 - What are you paying for this catheter?
- › How often do you use Catheter Directed Thrombolysis (CDT)?
- › How often to you use a Mechanical Thrombectomy device? How often to you use adjunctive CDT before or after the procedure?
- › What is your current protocol for CDT (is this the same for Arterial and Venous treatments)?
 - How do you currently treat thrombus in the arterial system?
 - How do you currently treat thrombus in the venous system?
- › How often do you bring patients back down for imaging when a CDT catheter is placed? 12, 18, 24 hours?
 - Do they keep the catheter in place during the imaging process?
 - If they remove the catheter do they replace it with a new one?
 - Would they benefit from a catheter that can act as an end-hole catheter in this procedure, instead of placing another flush catheter?
- › What are you paying for your current infusion (side-hole) catheter?
- › What is your annual procedure volume?

Uni-Fuse

INFUSION CATHETER

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INTRODUCE THE PRODUCT

- › **Number one—it's a side hole catheter, they're using side hole catheters, don't overcomplicate it just ask. Know the story.**
- › Slits NOT side holes → Pressure Response Outlets (PROs). Path of least resistance—it's basic fluid dynamics
- › Flow through hub and occluding ball wire—keeps it from kinking in tortuous anatomy and it can act as an end-hole catheter if necessary. This is an important piece of information.
 - Ask your physicians and techs what the current workflow is for CDT patients.
 - Most physicians will see a benefit to the ability so quickly switch from side hole to end-hole catheter for imaging purposes.

Tools: Brochures, product demonstration, iPad app, product demonstration with viscosity test, sample product.

EVALUATIONS/ADDITIONAL IN-SERVICING

Trialing the product is important (for any product category), although it may be a little different with Uni-Fuse as they are not frequently scheduled/used, like micro-access for instance. Make frequent stops into the lab and develop a relationship with the lead tech so that they'll call you when they have a case.

Key points to address and reiterate:

- › Why is it important to in-service Uni-Fuse?
 - Customers who do not use Uni-Fuse will not be familiar with the occluding ball wire and the need to leave in place for the catheter to perform as expected.
- › What is the most common mistake when using Uni-Fuse?
 - When removing the occluding ball wire from the packaging the plastic piece protecting the spring at the flow-thru h[ub end needs to be removed BEFORE inserting the occluding ball wire into the Uni-Fuse catheter.

CLOSING THE BUSINESS

You need to ASK for the business. Get buy-in from key players—your materials and purchasing managers, the physician users, and nurses who care for the patient during treatment.

This step will be driven by—

- › Your relationship with the account
- › Whether the account buying based on price or clinically
- › WHO you are selling to (Materials management, clinicians, both)

Make sure you understand the selling process and put realistic/accurate times frames within your forecasts and sales plans.

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TAKING IT TO THE NEXT LEVEL—SELLING CLINICALLY

Familiarize yourself with the procedure and hospital/doctor specific dosage and patient handling protocols (for example: patient taken to ICU or floor with specialized cardiac nurses? Drip lysis? Pressure bag? Imaging cadence, etc.) Know HOW tPA works.

Tissue plasminogen activator (tPA) produces clot lysis through the following sequence:

1. tPA binds to fibrin on the surface of the clot
2. Activates fibrin-bound plasminogen
3. Plasmin is cleaved from the plasminogen associated with the fibrin
4. Fibrin molecules are broken apart by the plasmin and the clot dissolves

So... tPA adheres to fibrin strands thus “dissolving” clot. Remember, a blood clot is made up of red blood cells, plasma, and fibrin. The older the thrombus is, the more fibrin strands develop. Because tPA adheres and breaks fibrin strands, it is beneficial to get the drug on as much surface area as possible—think SLITS vs SIDE HOLES.

USAT VS. CDT—CHALLENGE YOUR PHYSICIANS

Retrospective paper by Baker—No difference in USAT vs CDT

BERNutiful—EKO on vs. EKO off. No enhanced thrombolysis in USAT.

PERFECT—CDT effective in PE treatment.

All show little to no advantage of USAT vs. Thrombolysis.