Thrombate III®
antithrombin III (human)

For patients with hereditary antithrombin deficiency (hATd)

The right replacement—AT—the right time

Pregnant women are up to 5× more likely to experience venous thromboembolism (VTE) compared to the general population[1]

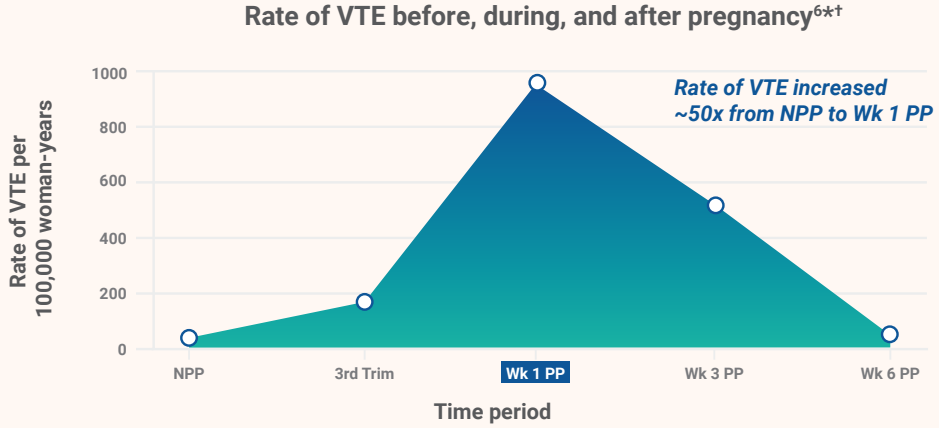
- Antithrombin (AT) levels decrease significantly from mid-second trimester to term in healthy women—and decrease even more steeply immediately after childbirth[2]
- AT deficiency is associated with increased rates of maternal morbidity and mortality, as well as greater healthcare resource utilization (HCRU)[3]

For pregnant women with hATd, the risk is even greater

- Up to 70% who do not receive prophylaxis experience thromboembolic complications[4,5]

Despite recommendations, rates of AT level testing and treatment in prenatal and postnatal patients remain relatively low[3]

Pregnant women are at the hightest risk for VTE around the time of delivery and in the first week of postpartum period[6]



*Rate using primary and secondary care data.[6]
†Includes only VTE diagnoses supported by prescription or evidence of anticoagulant therapy within 90 days of the event or death within 30 days of the event.[6]
NPP, non-pregnant period; PP, postpartum; Trim, trimester; Wk, week.

THROMBATE III provides safe, convenient, and accurate dosing to prevent thromboembolism throughout pregnancy and postpartum[7]

GRIFOLS

Please see Important Safety Information on back and accompanying full Prescribing Information for THROMBATE III.

Thrombate III®
antithrombin III (human)

Trusted for more than 30 years[7]

Safe & effective[7]

- Proven effective in treating and preventing thromboembolism in patients with hATd
- No reports of thrombotic complications during obstetrical and surgical procedures in clinical trials

Lower volume[7-9]

- Delivers 50× more AT than the same volume of fresh frozen plasma (FFP)
- Keeps volume load to a minimum
- No additional proteins and factors

Convenient[7]

- Accurate dosing that directly replaces the AT that's missing
- Rapid preparation when you need it most—before, during, or after surgery
- Stored at room temperature—no thawing required
- Can be used regardless of ABO status

Cost-effective[9]

- May be a cost-effective and timely option compared to FFP when considering administration, preparation, and additional expenses*

*Additional expenses associated with FFP may include overhead, transportation, defrosting time, and adverse event monitoring.

Learn more at
Thrombate.com

Important Safety Information

THROMBATE III® (antithrombin III [human]) is indicated in patients with hereditary antithrombin deficiency for treatment and prevention of thromboembolism and for prevention of perioperative and peripartum thromboembolism.

Hypersensitivity reactions may occur. Should evidence of an acute hypersensitivity reaction be observed, promptly interrupt the infusion and begin appropriate treatment.

Because THROMBATE III is made from human blood, it may carry a risk of transmitting infectious agents, eg, viruses, the variant Creutzfeldt-Jakob disease (vCJD) agent, and, theoretically, the Creutzfeldt-Jakob disease (CJD) agent. There is also the possibility that unknown infectious agents may be present in the product.

Perform coagulation tests to avoid excessive or insufficient anticoagulation and monitor for bleeding or thrombosis. Measure functional plasma AT levels with amidolytic or clotting assays; do not use immunoassays.

In clinical studies, the most common adverse reactions (≥5% of subjects) were dizziness, chest discomfort, nausea, dysgeusia, and pain (cramps).

The anticoagulant effect of heparin is enhanced by concurrent treatment with THROMBATE III in patients with hereditary AT deficiency. Thus, in order to avoid bleeding, the dosage of heparin (or low molecular weight heparin) may need to be reduced during treatment with THROMBATE III.

Please see full Prescribing Information for THROMBATE III.

References: 1. Springel EH, Malhotra T. Thromboembolism in pregnancy. Updated June 6, 2025. Accessed July 8, 2025. https://emedicine.medscape.com/article/2056380-overview. **2.** James AH, Rhee E, Thames B, et al. Characterization of antithrombin levels in pregnancy. *Thromb Res*. 2014;134(3):648-651. **3.** Federspiel JJ, Rodriguez W, Spears J, et al. Antithrombin testing and treatment in pregnancy: their real-world relationship to clinical outcomes. *Thromb Res*. 2024;241:109070. **4.** Hellgren M, Tengborn L, Abildgaard U. Pregnancy in women with congenital antithrombin III deficiency: experience of treatment with heparin and antithrombin. *Gynecol Obstet Invest*. 1982;14:127-141. **5.** James AH, Konkle BA, Bauer KA. Prevention and treatment of venous thromboembolism in pregnancy in patients with hereditary antithrombin deficiency. *Int J Womens Health*. 2013;5:233-241. **6.** Sultan AA, Tata LJ, Grainge MJ, West J. The incidence of first venous thromboembolism in and around pregnancy using linked primary and secondary care data: a population based cohort study from England and comparative meta-analysis. *PLoS One*. 2013;8(7):e70310. **7.** THROMBATE III® (antithrombin III [human]) Prescribing Information. Grifols. **8.** AABB, American Red Cross, America's Blood Centers, Armed Services Blood Program. Circular of information for the use of human blood and blood components. June 2024. Accessed July 21, 2025. https://www.aabb.org/docs/default-source/default-document-library/resources/circular-of-information-watermark.pdf?sfvrsn=7f5d28ab_5. **9.** Rodgers GM, Mahajerin A. Antithrombin therapy: current state and future outlook. *Clin Appl Thromb Hemost*. 2023;29:1-16.

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