The following must be submitted before the patient may be scheduled

☐ **Therapeutic Phlebotomy Order Form**
   An ICD10 code must be on the order corresponding to a condition for which Therapeutic Phlebotomy is deemed by Bloodworks to be medically necessary treatment (see attached list).
   **Orders with ICD10 codes not pre-approved by Bloodworks as associated with medical necessity must be accompanied by a written rationale for treatment by Therapeutic Phlebotomy and an Advance Beneficiary Notice of Noncoverage (ABN). The patient will not be scheduled until the Bloodworks Medical Staff has reviewed and concurs with medical necessity.**

☐ **Supporting laboratory test results (including CBC), pertinent patient records.**
   **Written rationale of medical necessity must be submitted when any non-standard treatment protocols are requested.**

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Please submit the completed Therapeutic Packets to the Therapeutic Phlebotomy Department by Fax or Mail.
Therapeutic Phlebotomy Order Form -
Erythrocytosis (Secondary Polycythemia)

<table>
<thead>
<tr>
<th>Patient’s Legal Name</th>
<th>Last</th>
<th>First</th>
<th>Middle Name or Initial</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>_________________________</td>
<td>_____________________</td>
<td>______________________</td>
</tr>
</tbody>
</table>

- Male [ ] Female [ ]

- Patient’s Birthdate __/__/____

- Best Contact Phone # (____)____________

- e-mail__________________________

- Street _______________________

- City _________________________

- State ________________________

- Zip Code ______________________

**Diagnosis:**

- Erythrocytosis heart related [ ]
- Cyanotic congenital heart disease, [ ]
- Cor Pulmonale, [ ]
- Arterio-Venous Fistula [ ]
- Erythrocytosis due to Erythropoietin [ ]
- tumor or [ ] renal disease (preliminary treatment pending definitive treatment of primary condition) [ ]
- Erythrocytosis due to Testosterone therapy (Medical necessity has not been established) [ ]
- Other ________________________ (Written explanation of the rationale for medical necessity must be submitted for review by the Bloodworks Medical Staff) [ ]

**Medical Necessity criteria (order must be accompanied by Hematocrit result taken within the last month):**

- Neurologic Symptoms of Hyperviscosity (specify symptoms)__________________________with Hct =___________ (AHA guidelines)

**Volume per phlebotomy:**

Orders for patients with conditions creating increased sensitivity to volume loss (e.g. elderly, pre-existing anemia, cardiac disease, lung disease, etc.) may be for less than 500 mL. Patients requiring concurrent intravenous hydration must be drawn at the Seattle Central Bloodworks location.

- Collect 500mL (patient must weigh 114lbs or more) [ ]
- Collect <500mL:__________________ (patient must weigh 114lbs or more) [ ]
- Collect volume based on patient weight (patient weighs less than 114lbs) **this will be determined at time of collection** [ ]

**Frequency:**

- One time only [ ]
- Every 8 weeks [ ]
- Every ____weeks [ ]
- Every ___months [ ]
- Other_____________________________

**Therapy of uncertain benefit:** The American Heart Association consensus guidelines are that phlebotomy is only indicated if the hematocrit is greater than 65% and there are neurologic deficits consistent with clinical evidence of Hyperviscosity. **Minimum Hematocrit:** Phlebotomy will not be performed if patient is already anemic (hematocrit less than 33%)

- If a higher minimum hematocrit threshold is desired due to decreased patient tolerance for anemia, please specify: _____%

Please identify if there are any Special Instructions or Precautions (if cardiac disease attach Bloodworks evaluation form):

________________________________________________________________________________________________________________________________________

**Health Care Provider Signature**_____________________________ **Provider NPI**___________ **Date**______

**Printed Provider Name**____________________________________ **Phone**________________ **Fax**___________

**Facility Address**_________________________________________ **Email**________________________

**Bloodworks Physician – please complete below once order has been reviewed and approved**

**Bloodworks Physician**_________________________ **Date**______

**Special Instructions for Therapeutic Phlebotomy Order Form is required** [ ] Yes [ ] No