Therapeutic Phlebotomy Order Form - Polycythemia Vera

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. The patient will not be scheduled until Bloodworks Medical Staff has reviewed and concurs with medical necessity.**

- Supporting laboratory test results (including CBC, JAK2/MPL, or pathology reports), other pertinent patient records. A written rationale of medical necessity must be submitted when any non-standard treatment protocols are requested.

Please submit the completed Therapeutic Packets to the Therapeutic Phlebotomy Department by Fax or Mail.
Therapeutic Phlebotomy Order Form - Polycythemia Vera

<table>
<thead>
<tr>
<th>Patient’s Legal Name</th>
<th>Last</th>
<th>First</th>
<th>Middle Name or Initial</th>
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- **Gender:**
  - Male
  - Female

- **Patient’s Birthdate:** ___/____/_____
- **Best Contact Phone #:** (____)___________
- **E-mail:** ____________________________

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<thead>
<tr>
<th>Patient’s Address</th>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
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**Diagnosis:** ICD10 code  _______________

- **Polycythemia Vera**
- If not previously treated at Bloodworks, submit documentation of the diagnosis of PCV (JAK2/MPL & CBC; or pathology reports)

**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**

**Orders must be resubmitted yearly.**

**Frequency:**

- Symptomatic hyperviscosity:  
  - Every other day IF hematocrit is ≥ 60%, until less than 60%
- Routine therapy:  
  - Once a week
  - Every 2 weeks
  - Monthly
  - Every ___ weeks
  - Every ___ months
  - Other __________

**Minimum Hematocrit:** Phlebotomy will not be performed if patient is already anemic (hematocrit less than 40%)

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

**Requests for non-standard indications/treatment protocols:** *Requests for treatment of myeloproliferative neoplasms other than Polycythemia Vera or non-standard phlebotomy protocols must be accompanied by documentation of the rationale for deviation from standard therapy and will require approval by Bloodworks Medical Staff prior to scheduling treatments.

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

______________________________________________________________________________________________________

**Health Care Provider**

<table>
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<tr>
<th>Signature</th>
<th>Provider NPI</th>
<th>Date</th>
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**Facility Address**

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<tr>
<th>Phone</th>
<th>Fax</th>
<th>Email</th>
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**Bloodworks Physician – please sign and date once order has been reviewed and approved**

**Bloodworks Physician**

<table>
<thead>
<tr>
<th>Date</th>
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</table>

Special Instructions for Therapeutic Phlebotomy Order Form is required  
- Yes  
- No