



<i>Blood Center Use only</i>	
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Therapeutic Phlebotomy Department
 1021 112th Ave NE Bellevue, WA 98004
 (800) 266-4033 or (425) 453-5098 Fax (425) 462-4316
 Email: therapeuticphlebotomy@psbc.org

**Therapeutic Phlebotomy Order Form -
 Erythrocytosis
 (Secondary Polycythemia)**

The following must be submitted before the patient may be scheduled

- Therapeutic Phlebotomy Order Form**
 An ICD9 code must be on the order corresponding to a condition for which Therapeutic Phlebotomy is deemed by PSBC to be medically necessary treatment (see attached list).
Orders with ICD9 codes not pre-approved by PSBC 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 Puget Sound Blood Center Medical Staff has reviewed and concurs with medical necessity.

- Advance Beneficiary Notice of Noncoverage (ABN) – (must be completed for Medicare patients where the reason for phlebotomy is not covered by insurance) please visit <http://www.cms.gov/Medicare/Medicare-General-Information/BN/ABN.html> for questions or information on when and how to complete the ABN Form No. OMB 0938-0566**

- 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.

Please submit the completed Therapeutic Packets to the Therapeutic Phlebotomy Department by:
Fax: 425-462-4316
Mail: Puget Sound Blood Center
1021 112th Ave NE
Bellevue, WA 98004



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Therapeutic Phlebotomy Order Form - Erythrocytosis (Secondary Polycythemia)

Patient's Legal Name _____			
Last		First	Middle Name or Initial
<input type="checkbox"/> Male <input type="checkbox"/> Female	Patient's Birthdate ___/___/___	Best Contact Phone # (____) _____	e-mail _____
Patient's Address _____			
Street		City	State Zip Code

Diagnosis: ICD9 Code _____

- 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 PSBC Medical Staff)

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

- Hemoglobin >20 mg/dL or Hematocrit >65%
- Neurologic Symptoms of Hyperviscosity (specify symptoms) _____ with Hgb/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.) should be for less than one unit. Patients requiring concurrent intravenous hydration must be drawn at the Seattle Central Puget Sound Blood Center location.

- Collect 500mL (patient must weigh 110lbs or more)
- Collect <500mL: _____ (patient must weigh 110lbs or more)
- Collect volume based on patient weight (patient weighs less than 110lbs) **** this will be determined at time of collection**

Frequency: (not to exceed one unit every 8 weeks, unless hemoglobin ≥20 g/dL)

- One time only Every 8 weeks Every ___ weeks Every ___ months Other _____

Do not perform phlebotomy if hemoglobin is <20g/dL (Criteria for medical necessity per AHA, and most third party payers)
Do not perform phlebotomy if hemoglobin <16.5 g/dL <18 g/dL

Therapy of uncertain benefit: The American Heart Association consensus guidelines are that phlebotomy is only indicated if the hemoglobin is ≥20 g/dL or the hematocrit is greater than 65% and there are neurologic deficits consistent with clinical evidence of hyperviscosity.

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

Health Care Provider Signature _____ **Provider NPI** _____ **Date** _____

Printed Provider Name _____ **Phone** _____ **Fax** _____

Facility Address _____ **Email** _____

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

PSBC Physician _____ **Date** _____

Special Instructions for Therapeutic Phlebotomy Order Form is required Yes No ABN recommended Yes No