Puget Sound Blood Center
blood services | medicine | research

| Blood Center Use only | |
|---|---|
| Processed by | |
| Verified by | |

**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 - Hemochromatosis Maintenance

**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. The patient will not be scheduled until the Puget Sound Blood Center Medical Staff has reviewed and concurs with medical necessity*
- ❑ **Supporting laboratory test results, patient records. A written rationale of medical necessity must be submitted when any non-standard treatment protocols are requested.**

**Examples of required supporting documentation:**

- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

**First time treatment at PSBC**

**❑ Medical necessity form accompanied by ❑ laboratory reports or other documentation of clinical iron overloading establishing medical necessity must accompany the orders (typically fasting transferrin >45% more than once)**

**Frequent phlebotomy (>12 times a year; orders expire every 3 months)**

**Maintenance phase (≤12 times a year; orders expire every 12 months)**

**❑ Maintenance Phase Order Form accompanied by ❑ laboratory reports for ferritin monitoring over the preceding year**

**Non-standard phlebotomy protocols including:**

**Phlebotomy treatment if HCT <33% (chelation is considered treatment of choice)**
**Frequent phlebotomy for more than 1 year**
**Maintenance phase treatment where HCT is below the reference interval**

**❑ Written explanation of the rationale for non-standard treatment must be submitted for PSBC Medical Staff review and approval before the patient can be scheduled.**

**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**

Puget Sound Blood Center
blood services | medicine | research

| Blood Center Use only | |
|---|---|
| Processed by | |
| Verified by | |

**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 - Hemochromatosis, Maintenance Phase

(Order expires every 12 months)

**Patient's Legal Name**_____ _____ _____
Last First Middle Name or Initial

❑ **Male** ❑ **Female** **Patient's Birthdate** ___/____/_____ **Best Contact Phone #** (____)_____ **e-mail**_____

**Patient's Address** _____ _____ _____ _____
Street City State Zip Code

**Diagnosis: ICD9 code** _____

❑ **Hereditary hemochromatosis (both alleles mutated by genetic testing)**
❑ **Unspecified (Presumed Hereditary hemochromatosis without confirmatory genetic testing performed)**

❑ **Iron overloading due to other causes** (Medical necessity not generally accepted, submit written treatment rationale)
❑ Hepatitis ❑ Other liver disease ❑ Medications/Toxins ❑ Inflammatory disease ❑ African iron overload
❑ Hemolysis ❑ Transfusional iron overload ❑ Sideroblastic anemia ❑ Other_____

**Maintenance phase:** Orders for maintenance phlebotomy (≤12 times a year), must be resubmitted every year, accompanied by the ferritin monitoring results over the prior year of therapy including one result since the last treatment.

**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 Puget Sound Blood Center 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:**
❑ **Monthly** ❑ **Every** _____ **weeks** ❑ **Every** _____ **months** ❑ **Other**_____

**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 PSBC evaluation form):**

_____

**Health Care Provider**
**Signature**_____ **Provider NPI**_____ **Date**_____
**Printed Provider Name**_____ **Phone**_____ **Fax**_____
**Facility Address**_____ **Email**_____

**PSBC Physician – please sign and date once order has been reviewed and approved**

**PSBC Physician**_____**Date**_____
Special Instructions for Therapeutic Phlebotomy Order Form is required ❑ Yes ❑ No



14-9-038 01
DVR 0040D