Therapeutic Phlebotomy Order Form - Hemochromatosis Maintenance

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 the Bloodworks 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:**

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**First time treatment at Bloodworks**

- 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 Bloodworks Medical Staff review and approval before the patient can be scheduled.

Please submit the completed Therapeutic Packets to the Therapeutic Phlebotomy Department by Fax or Mail.
Therapeutic Phlebotomy Order Form - Hemochromatosis, Maintenance Phase  
(Order expires every 12 months)

<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**

<table>
<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 _________________________

- [ ] 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 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:**

- [ ] 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 Bloodworks evaluation form):

____________________________________________________________________________________________________

**Health Care Provider**

Signature ___________________________________ Provider NPI_________________ Date___________

Printed Provider Name ________________________ Phone________________ Fax___________

Facility Address ______________________________ Email________________________

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

Bloodworks Physician________________________ Date___________

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