

<b>Blood Center Use only</b>	
<b>Processed by</b>	
<b>Verified by</b>	

**Therapeutic Phlebotomy Department**  
Time Square, 660 SW 39<sup>th</sup> Street, Suite 245, Renton, WA 98057  
(800) 266-4033 or (425) 453-5098 Fax (425) 251-1977  
**Email:** therapeuticphlebotomy@bloodworksnw.org

**Therapeutic Phlebotomy Order Form -  
Hemochromatosis Rapid Iron Removal Phase**

**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:**

-----

**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)**

- Initial Rapid Iron Removal Form accompanied by  laboratory report(s) of ferritin monitoring, one of which must be from within the last month Maintenance phase (≤12 times a year; orders expire every 12 months)**

- 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.**



<b>Blood Center Use only</b>	
Processed by	
Verified by	

**Therapeutic Phlebotomy Department**  
 Time Square, 660 SW 39<sup>th</sup> Street, Suite 245, Renton, WA 98057  
 (800) 266-4033 or (425) 453-5098 Fax (425) 251-1977  
 Email: therapeuticphlebotomy@bloodworksnw.org

**Therapeutic Phlebotomy Order Form -  
 Hemochromatosis Rapid Iron Removal Phase**  
*(Order only valid for 3 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: ICD10 code \_\_\_\_\_

Hereditary hemochromatosis (both alleles mutated by genetic testing)  
 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 \_\_\_\_\_

**Initial Rapid Iron Removal Phase (up to one year):**  
 Orders for **frequent phlebotomy** (more than 12 times a year) for rapid iron removal **must be resubmitted every 3 months**, accompanied by ferritin results including one value in the preceding month (CDC guidance is ferritin monitoring every 4 – 8 weeks until ferritin <1000, then more frequently, at least every 2 weeks once ferritin <100 ng/dL).

**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:** (not to exceed one unit per week, if ferritin >100 ng/mL ; not to exceed one unit per month if ferritin ≤ 100 ng/mL)  
 One time only  Weekly  Monthly  Every \_\_\_ weeks  Other \_\_\_\_\_  
**Maximum number of phlebotomies per order is 13.**

**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