Bloodworks

Blood Center Use only	
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Verified by	

Therapeutic Phlebotomy Department
Time Square, 660 SW 39th 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 - 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.

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Therapeutic Phlebotomy Order Form - Polycythemia Vera

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 _____

❑ **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 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