Blood Center Use only	
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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 - Porphyria Cutanea Tarda

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, patient records**

For patients new to Bloodworks:

Submit documentation of the diagnosis of PCT vs. other porphyrias (which do not respond to iron reduction), such as porphyrin testing showing PCT pattern (predominance of plasma uroporphyrin, hepatcarboyxl porphryrin >> hexa- & penat-carboxyl porphyrins; lack of Erthryocyte porphryins, minimal urine coproporhyrin)

- -

Requests for treatment of unusual frequency/duration or for phlebotomy despite pre-existing anemia (Hct<33%):
Must be accompanied by documentation of re-evaluation for co-morbid conditions interfering with iron removal, or interfering with ferritin monitoring (ferritin may not reflect iron status if concurrent inflammation).

❑**If phlebotomy is required beyond the first 6 months (13 units):**
Submit documentation of ferritin remaining >20 ng/do, evaluation for presence of concurrent Hereditary hemochromatosis, and continued clinical symptoms requiring further treatment.

Please submit the completed Therapeutic Packets to the Special Collections Department by Fax.

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Therapeutic Phlebotomy Order Form - Porphyria Cutanea Tarda

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 _____

❑ **Porphyria Cutanea Tarda**
If concurrent Hereditary Hemochromatosis, see separate order set for Hereditary hemochromatosis therapeutic phlebotomy protocol

❑ **Submit documentation of the diagnosis of PCT** vs. other porphyrias (do not respond to iron reduction) such as results of porphyrin testing showing PCT pattern

Iron Removal: *Most patients should achieve iron reduction (ferritin near 25 ng/mL after phlebotomy every 2 weeks up to 8 units.) Lack of ferritin response with the standard protocol should prompt re-evaluation of the patient for other diseases including concurrent Hereditary hemochromatosis, and non-specific causes of increased ferritin such as inflammatory states.*

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 standard therapy of one unit every two weeks until ferritin <25 ng/mL)
❑ **One time only** ❑ **Monthly** ❑ **Every ____weeks** ❑ **Every ___months** ❑ **Other**_____
Many patients do not require maintenance phlebotomy after initial iron reduction. Consider observation prior to ordering maintenance.

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**: _____%**

Requests for non-standard treatment protocols: *Requests for non-standard treatment 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 complete below once order has been reviewed and approved

Bloodworks Physician_____ **Date**_____

Special Instructions for Therapeutic Phlebotomy Order Form is required ❑ Yes ❑ No