Absolute Genomics

Molecular Test Requisition (Orange Section Required)

INSURANCE ORDERING CHECKLIST

1. Sample Collection Date
2. List/Copy of Patient's Current Medications
3. Patients Name with a copy of Demographic/FACE sheet
4. Check appropriate panel type
5. Copy of Patient's insurance card
6. Check ALL applicable diagnosis codes (see back or add if not listed)
7. PROVIDER NOTES: "PGx done today; will follow up when results are reported"
8. Patient and Physician names and signatures

PATIENT INFORMATION

Last Name	First Name	Middle Initial	(MM/DD/YY)	
Street Address	City		State/Country	Zip
Preferred Contact Phone Number	Biological Sex: ☐ F ☐ M Gender Identity (If different from marked:) _____		Ethnicity: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Jewish (Ashkenazi) ☐ Portuguese ☐ Other: _____	

SPECIMEN INFORMATION

Type(s) ☐ Buccal swab	Date of Collection (MM/DD/YY)	Initials of Individual Collecting Specimen
LABORATORY USE ONLY:	DATE RECEIVED: ACCESSION NO:	SPECIMEN ID:

SENDING FACILITY

Facility Type: ☐ Physician/Physician Group ☐ Referral Lab

Facility Name (Facility Code)	Address	City	State/Country	Zip	Phone

ORDERING PHYSICIAN AND/OR OTHER LICENSED MEDICAL PROFESSIONAL

Name (Last, Frist, Degree) (Clinician Code)	Phone	Fax	Email	NPI#

ADDITIONAL RESULT RECIPIENTS

☐ Primary Contact	Medical Professional Name (Clinician Code)	Phone	Email or Fax
☐ Primary Contact	Genetic Counselor Name (Clinician Code)	Phone	Email or Fax

CONFIRMATION OF INFORMED CONSENT AND MEDICAL NECESSITY FOR GENETIC TESTING

By signing this form, the medical professional acknowledges that the individual/family member authorized to make decisions for the individual (collectively, the "Patient") has been supplied information regarding and consented to undergo selected testing, substantially as set forth in Absolute Genomics informed Consent for selected testing and has been informed that Absolute Genomics may notify them of clinical updates related to test results (in consulting with ordering medical professional as indicated). I agree to allow Absolute Genomics to facilitate the provision of pre-test, counseling, if required by insurer, services by a third-party service, unless otherwise indicated by checking this box. No test other than the specific test ordered shall be performed on the biological sample. I, the undersigned, understand that I am responsible for all co-pays and deductibles, and for amounts not covered by insurance. By signing this authorization. I acknowledge that payments be made on my behalf to Absolute Genomics for any services provided to me by Absolute Genomics. I also allow the release of any medical information necessary to process this claim. Appeal Authorization: In the event of an underpayment or denial by my insurance carrier, I hereby authorize the lab parties or their designee, to appeal my health plan on my behalf to provide the actions and information necessary to overturn the denial or receive reimbursement for the underpaid claim. This authorization shall remain valid until the charges for the orders on this form are paid in full.

Donor Signature: I certify that I provided my specimen to the collector; that I have not adulterated it in any manner; each specimen used was sealed in my presence; and that the information provided on this form and on the label affixed to each specimen is correct. I authorize the release of the results to the ordering clinician, authorized client/representative, or prescribing/attending physician. I authorize the entity to release any information required for billing purposes. I acknowledge the entity may be an out of network provider with my insurer. I understand I have the option of obtaining lab services from another facility and that, upon my request, will be provided a list of alternative lab facilities. I understand that I am responsible for payment of any deductibles or co-insurance charges. I also agree that in a case where my insurance provider sends payment directly to me, I will endorse the insurance check and forward to the entity within 30 days.

I understand that all personal health information will be treated confidentially, in accordance with applicable state and federal law, where such practices and rights concern personal health information.

I have read, understand, and agree to the Medical Necessity/Informed Consent above and the test services being performed.

Patient Signature _____ Date _____

☐ INSURANCE BILLING (include copy of both sides of insurance card)

☐ Self ☐ Spouse ☐ Child	Name and DOB of Policy Holder (if not self)	
Insurance Company	Policy #	Pre Authorization#

☐ PATIENT PAYMENT

☐ Check ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Card Number	Exp. Date	CVC#
Cardholder	Amount $	

☐ INSTITUTIONAL BILLING

Facility Name	
Street Address	
City	
State	Zip
Contact Name	
Phone Number	Email

PGx TEST REQUESTED

☐ **GENERAL GENE PANEL**	*ABCB1, ABCG2, ABHD6, ABHD12, ACADM, ACE, ADRA2A, ADRB1, ADRB2, AGT, APOB, APOE, BCKDHA, CACNA1C, CES1, CFTR, CNR1, CNR2, COMT, COX2, CYP1A1, CYP1A2, CYP2A6, CYP2B6, CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, DPYD, DRD1, DRD2, DRD3, EDN1,F2, F5, F7, F9, FAAH, GNB3, GPR55, GRIK4, HTR1A, HTR2A, HTR2C, IFNL3, IVD, KCNIP1, LDLR, LPA, MAPK14, MTHFR, NR1H3, NUDT15, OPRM1, RYR1, SLC6A2, SLCO1B1, TPMT, TRPV1, VKORC1*
☐ **CARDIAC GENE PANEL**	*ABCB1, ACE, ADRB1, ADRB2, AGT, APOB, APOE, CACNA1C, CYP2A6, CYP2C19, CYP2D6, CYP3A4, CYP3A5, EDN1, F2, F5, F7, F9, GNB3, KCNIP1, LDLR, NR1H3, RYR1, SLC6A2, SLCO1B1, VKORC1*
☐ **PSYCH GENE PANEL**	*ABCB1, ADRA2A, APOE, CES1, CNR1, COMT, CYP1A2, CYP2B6, CYP2C19. CYP2D6, CYP3A4, CYP3A5, DRD1, DRD2, FAAH, GRIK4, HTR1A, HTR2A, HTR2C, IVD, MTHFR, OPRM1, SLC6A2*
☐ **PAIN MANAGEMENT GENE PANEL**	*ABCG2, COX2, CYP1A2, CYP2C19, CYP2C9, CYP2D6, CTP3A4, DRD1, DRD2, DRD3, OPRM1, RYR1, TRPV1*

Molecular Test Requisition **Patient Name:** _____ **DOB:** _____

ICD-10 CODES

_____

_____

_____

Provider Referral for Pharmacogenetic Testing

ATTENTION INSURANCE REPRESENTATIVE: The following information is provided as proof of medical necessity. For additional information and provider signature, please see the full requisition.

Reasons for Pharmacogenetic Testing

• Reduce medical liability through targeted treatments	• Reduce repeat visits for dosage adjustments
• Reduce health care costs – ER visits, secondary medications to treat primary medication side effects	• Address acute care issues with proper medication before they trend into chronic care issues
• Identify & reduce unnecessary risks related to drug-drug interactions, contraindications, anticholinergic burden, adverse drug reactions, Beers criteria, & lifestyle factors	• Improved patient compliance & patient outcome by reducing unnecessary side effects, time to resolve health issues, and costs related to current drug regimen.
• Reduce Adverse Drug Reactions (ADRs) – responsible for over 117,000 deaths in 2013	• Adherence to FDA Black Box Warning guidelines and to support the growing trend of companion diagnostics

My patient (full name & DOB recorded on test requisition) has medical conditions requiring multiple prescription drugs. Given this patient's current or potential polypharmacy regimen, testing for drug metabolism and certain genetic risk factors is medically necessary. These indications are clearly documented in the patient's medical record.

I, the provider, have ordered this testing for this specific patient in order to understand the possible dangers and risks for suboptimal outcomes for specific medications currently prescribed or under consideration.

This test will assess the following for this patient:

• High potential for adverse drug reaction/episodic events	• Efficacy of current and/or future drug therapy
• Potential risk of developing venous thrombosis and/or cardiovascular disease	• Drug therapy best matched to patient's metabolic genotype/phenotype
• Identify potential source(s) of side-effect type illnesses	• Reduce number of necessary medications in regimen
• Correct dosage(s) to maximize therapeutic effect	• Other:

Provider Indications (please check) – I plan to use information obtained from this test to improve this patient's care and to:

☐ Identify current medications that may be causing adverse reactions	☐ Determine the optimal dosage(s) for current or future prescriptions to ensure maximum therapeutic efficacy
☐ Identify and prescribe cost effective medications to maximize therapeutic efficacy while minimizing the potential risk of adverse reactions	
☐ Other:	

CONFIRMATION OF INFORMED CONSENT AND MEDICAL NECESSITY FOR GENETIC TESTING

To be medically necessary, diagnostic laboratory tests must be ordered by an Ordering Medical Provider (an individual with an NPI number).

I request and authorize Absolute Genomics to perform the designated test(s) on the sample provided by me as well as provide clinical reporting for the attached sample. I have supplied information regarding testing and the patient has given consent for testing to be performed. My signature constitutes as a Certification of Medical Necessity and a certification of the following: when ordering testing for which reimbursement from Medicare, Medicaid, or other third party payers will be sought by Absolute Genomics I acknowledge and understand the our network of Labs will perform laboratory testing for my patients and sometime this testing will be billed as a out-of-network provider. I acknowledge that I am solely responsible for adhering to any applicable policies, procedures, or protocols for the referral of specimens to an out-of-network laboratory established by commercial payers with whom I or my practice may be contracted. I acknowledge and agree that the network of labs has made no representations regarding my ability to utilize for my patients with respect to such applicable polices, procedures, or protocols. I certify that the ordered test is reasonable and medically necessary for the diagnosis, care, and treatment of this patient's condition. I also authorize Absolute Genomics to send on my behalf, test results to the patient's third party payer in connection with an appeal of a reimbursement denial or other reimbursement matter. Signature below also applies to the Provider Referral for Pharmacogenetic Testing.

My signature here applies to the attached letter of medical necessity **(LMN)** (if applicable). If you do not want your signature on **this requisition form** to apply to the attached LMN, please provide an LMN and/or Clinical Notes with your order and check here. ☐No

Medical Professional Signature:_____ **Date:** _____