PHARMACOGENETIC TEST REQUISITION FORM

Please verify the information below is included with each sample:
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. Provide all applicable diagnosis codes (see separate document)
7. Patient and Physician names and signatures

Practice information:

1 Patient information:

Patient **Last Name**	Patient **First Name**	Patient Street Address	
City	State	Zip Code	Date of Birth (MM/DD/YY) _______/_______/_________
Patient Phone #	Gender ☐ Male ☐ Female	Height	Weight

Buccal Swab Sample Collection Date (MM/DD/YYYY) ______/______/________	Patient Medications (Please attach patient face sheet)

Provider Notes:

Patient Ethnicity
- ☐ White
- ☐ Mixed Race
- ☐ Hispanic/Latino
- ☐ American Indian/Native Alaskan
- ☐ Asian
- ☐ Hawaiian/Pacific Islander
- ☐ Other/Unknown
- ☐ African American

2 Payment and Insurance Information:

☐ Medicare ☐ Commercial Other

Complete section below **AND** include photocopy of both sides of insurance card or face sheet

☐ Bill Insurance [ ] Pre-Authorization Number if Applicable ☐ Patient Direct Pay

Primary Insurance	ID Number	Group Number
Secondary Insurance	ID Number	Group Number
Name of Person Insured	Relationship to Insured	Date of Birth (MM/DD/YY) _______/_______/__________

3 ICD-10 Codes *(SEE SEPARATE DOCUMENT and list all applicable codes)*

______________________________ ______________________________ ______________________________ ______________________________

4 Testing Options

Panel	Genes
☐ G001 – Cardio Panel	CYP2C9, CYP2C19, CYP2D6, CYP3A4/5, CACNA1C, MTHFR, VKORC1, SLCO1B1, ITGB3, ABCG2, 12q15, NOS3, LPA, APOE, Factor II/V
☐ G002 – Pain Panel	CYP2C9, CYP2C19, CYP2D6, CYP2B6, COMT, OPRM, CYP1A2
☐ G003 – Psych Panel	CYP2C9, CYP2C19, CYP2D6, CYP3A4/5, CYP2B6, CYP1A2, COMT, ANKK1/DRD2, GRIK4, UGT2B15, ADRA2A, SLC6A4, HTR2A, HTR2C, DRD2, FKBP5, BDNF, CACNA1C, ANK3, MTHFR
☐ G004 – Comp Panel	CYP1A2, CYP2C9, CYP2C19, CYP2D6, CYP2B6, CYP3A4/5, SLCO1B1, VKORC1, COMT, OPRM1, Apo MTHFR, ANKK1/DRD2
☐ G005 – Extended Comp Panel	GRIK4, ADRA2A, SLC6A4, HTR2A, HTR2C, DRD2, FKBP5, BDNF, CACNA1C, ANK3, TPMT, ITGB3, SLC47A2, C11orf65, NOS3, DBH, GRIK1, GRIN2B, G6PD, DPYD, LPA, ALDH2, ADH1B, ABCG2, 12Q15, SCN1A, CYP2C8

5 Patient authorization and informed consent

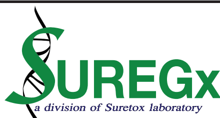
I request and authorize Suretox to perform the designated test(s) on the DNA sample provided by me. My signature below constitutes my acknowledgment that I have been informed of the benefits and limitations of this testing which have been explained to my satisfaction by a qualified health professional. Assignment of Benefits: I hereby authorize Suretox or its affiliate to bill my insurance company and receive payment from them on my behalf. I acknowledge, however, that I am responsible for payment of my account and any and all charges associated with its collection. I herby authorize my insurance company to pay the company directly for services rendered. Appeal Authorization: In the event of an underpayment or denial by my insurance carrier, I hereby authorize the company 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 Suretox or its affiliates to release any information required for billing purposes. I acknowledge Suretox or its affiliates may be an out of network provider with my insurer. I agree that if my insurance provider sends payment directly to me, I will endorse the insurance check and forward within 30 days to Suretox Laboratory 30 days to 495 Boulevard Suite 1 A, Elmwood Park, NJ 07407.

Patient Name	**Patient** Signature **Date** ______/_______/_______

6 Physician informed consent and medical necessity statement (Required rational and application options on back)

Physician Certification: I hereby request and authorize reference/testing lab to utilize this information to perform pharmacogenetic testing for the indicated patient. I certify that I have explained pharmacogenetic testing to the patient indicated in this requisition form. I also certify that I will only use and disclose test results as permitted by law.

Physician Authorizing Name	**Physician** Authorizing Signature **Date** ______/_______/_______



495 Boulevard Suite 1A, Elmwood Park, NJ 07407
P (201) 791-7293 F (866) 425-4630

7

Pt. Name _______________

Date_______D.O.B._______

BAR CODE/////////

Required Medical Necessity Information

Test Rational	Test Application (check all that apply)
☐ Patient's condition appears difficult to treat as evidence by therapeutic failure of previous medication trials ☐ Patient has demonstrated sensitivity or lack of symptom with relief with recommended medication dosage ☐ Patient is on multiple medications for their condition which increases the risk of adverse drug reactions ☐ Patient has been noncompliant with the medication treatment regimen due to adverse drug reactions ☐ Patient is experiencing unpleasant or intolerable side effects on their current medication regimen ☐ Patient has a history of medication sensitivity and/or adverse drug reactions ☐ Patient is suspected of abusing and/or diverting with current medication(s) ☐ Initial onset of condition in patient with no pharmacological treatment history for condition ☐ There is a "Warning" in the package insert of the medications being considered ☐ Desired medication for patient is a "Controlled Substance" Medication Class is new to the patient ☐ An "inhibitor' or "Inducer" may affect therapeutic response to prescribed medication ☐ Other diagnostic or medical reason not noted: Note:__________________________ Addition Medical Notes: __________________________ ____ ____ ____ ____	☐ Medications to avoid in order to decrease the risk of side effects that could lead to noncompliance or treatment discontinuation by the patient ☐ Dosing changes required to decrease side effects the patients is experiencing on current medication(s) ☐ Medications to avoid to decrease or eliminate the risk of serious adverse events known to occur with certain medications or classes of medications used to treat the patient's condition ☐ Dosing changes required to reduce the risk of an adverse event(s) occurring or recurring with the medication selected to treat the patient ☐ Medication which could be utilized to increase the likelihood of achieving a therapeutic response ☐ Dosing changes required to optimize therapeutic response on current medication(s) ☐ Important metabolic interactions resulting from the concomitant use of other prescription medication(s) ☐ Important metabolic interactions resulting from the concomitant use of other over-the-couter or herbal medication(s)