NRLBH
Powered by Atossa Genetics

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PGx Test Request Form

ORDERING PHYSICIAN INFORMATION

Physician Name ________________

Clinic Address ________________

City ________ State ________ Zip code ________

Phone ________ Fax ________

Medical Professional Authorization and Consent

I hereby authorize testing for this patient. I have supplied information regarding testing and the patient has given consent for testing to be performed. My signature constitutes 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 NRLBH, I certify that the below ordered test is reasonable and medically necessary for the diagnosis, care, and treatment of this patient's condition. I also hereby authorize NRLBH to send on my behalf this patient's test results to the patient's third party payer in connection with an appeal of a reimbursement denial or other reimbursement matter; but only where NRLBH has made prior attempts to obtain reimbursement without the release of such test results.

Does this patient consent to the use of their sample for research? ☐ Yes ☐ No

Consent is implied if box is not marked. (New York law requires residents to indicate consent)

Physician Authorization Signature **Date**

PATIENT INFORMATION

Patient Last Name ________ First Name ________

Gender ☐ Female ☐ Male DOB ______/______/________

Street Address ________________

City ________ State ________ Zip code ________

Phone ________ MR# ________

Ethnic Background ☐ African American ☐ Caucasian ☐ Jewish-Ashkenazi ☐ Asian ☐ Hispanic ☐ Other________________

MEDICATION LIST

CURRENT MEDICATION LIST (Please attach list of current medications if available)

INTENDED MEDICATION LIST

STATEMENT OF MEDICAL NECESSITY

Primary ICD-9 Code:
REQUIRED

Please state why the patient needs this test and any past testing experience to support treatment decisions.
A partial list of ICD-9 codes is provided as a reference and is not exhaustive.

- ☐ 244.9 Hypothyroidism, unspec.
- ☐ 250.00 Diabetes type II or unspec., uncomplicated
- ☐ 250.01 Diabetes type I, uncomplicated
- ☐ 272.0 Hypercholesterolemia, pure
- ☐ 272.2 Hyperlipidemia, mixed
- ☐ 272.4 Hyperlipidemia, unspec.
- ☐ 300.00 Anxiety state, unspec.
- ☐ 311 Depressive disorder, NOS
- ☐ 346.90 Migraine, unspec., not intractable
- ☐ 401.1 Hypertension, benign
- ☐ 401.9 Hypertension, unspec.
- ☐ 414.00 Coronary atherosclerosis
- ☐ 414.9 Chronic ischemic heart disease, unspec.
- ☐ 428.0 Congestive heart failure, unspec.
- ☐ 491.21 Obstructive chronic bronchitis, w/ exacerbation
- ☐ 496 Chronic airway obstruction, NEC
- ☐ 530.81 Gastroesophageal reflux, no esophagitis
- ☐ 715.09 Osteoarthrosis, general multiple sites
- ☐ 715.90 Osteoarthrosis, unspec.
- ☐ 716.90 Arthropathy, unspec.
- ☐ 719.46 Pain, knee
- ☐ 723.1 Pain, neck
- ☐ 723.9 Cervical disorder, NOS
- ☐ 724.2 Pain, low back
- ☐ 724.4 Back pain w/ radiation, unspec.
- ☐ 726.10 Rotator cuff syndrome, NOS
- ☐ 729.1 Myalgia, myositis, unspec.
- ☐ 729.5 Pain in limb
- ☐ 780.79 Fatigue and malaise, other
- ☐ 782.1 Rash, nonspecific skin eruption
- ☐ 784.0 Headache, unspec.
- ☐ 785.1 Palpitations
- ☐ 786.05 Shortness of breath
- ☐ 786.50 Chest pain, unspec.
- ☐ 787.01 Nausea w/ vomiting
- ☐ 995.20 Medication, adverse effects, unspec.

Other ICD-9 Codes:

SPECIMEN INFORMATION

Date of Collection: ______/______/________

Specimen Type: ☐ **Buccal Swabs**

TEST MENU

PANELS:

COMPREHENSIVE PANEL
(ABCB1, CYP2C9, CYP2C19, CYP2D6, CYP3A4/CYP3A5, Factor II, Factor V Leiden, MTHFR, VKORC1)
- ☐ **Full Dosing Recommendation**
- ☐ **Cardiovascular Dosing Recommendation**

CYP450 PANEL
(CYP2C9, CYP2C19, CYP2D6, CYP3A4/CYP3A5)
- ☐ **Pain Management Dosing Recommendation**
- ☐ **Psychiatric Dosing Recommendation**

THROMBOSIS RISK PANEL
- ☐ Factor II, Factor V Leiden, MTHFR

INDIVIDUAL TESTS:

- ☐ ABCB1
- ☐ CYP2C9
- ☐ CYP2C19
- ☐ CYP2D6
- ☐ CYP3A4 / CYP3A5
- ☐ Factor II
- ☐ Factor V Leiden
- ☐ MTHFR
- ☐ VKORC1

BILLING AND CONSENT

Patient initials required

Required: Please include front and back copy of valid insurance card(s). If attaching office insurance demographic sheet, **must** include **claim mailing address and phone number**.

If patient is not the primary policy holder, the following information is REQUIRED or testing may be delayed.

Bill to: ☐ Insurance ☐ Patient Self-Pay

Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other ____________

Policy Holder Name: ________________

Policy Holder DOB: _____/_____/_______

Primary Insurance Name: ________________

Policy ID: ________________ Group ID: ________________

By initialing here, you are providing the consent set forth on the reverse side of this form and you are agreeing to pay NRLBH upon receipt of a bill all co-payments, co-insurance, deductibles and any fees that are not covered by your insurance. Please initial once you understand and have read the NRLBH billing policy.

Patient Initials __________

Patient Consent Form

Intended Purpose: Pharmacogenomics Testing

1. Your test results will indicate the type of gene that you carry (genotype) and how your body may metabolize medications (phenotype).

2. Your test results will be sent to your healthcare provider who will review them with you.

3. All test results are treated with strict medical confidentiality as required by Washington State and federal law. If your insurance provider requires test results for reimbursement purposes, NRLBH is obligated to release them. Note: Patients are protected by the Genetic Information Nondiscrimination Act (GINA) of 2008: a federal law that prohibits discrimination in health coverage and employment, based on genetic information.

4. The performance characteristics of these tests have been validated by NRLBH. These various tests are also known as Laboratory Developed Tests (LDT's). NRLBH is certified by the Clinical Laboratory Improvement Amendments (CLIA) to perform high-complexity clinical testing. The U.S. Food and Drug Administration (FDA) has not approved these LDT's and FDA approval is currently not required for the clinical use of this test. FDA approval or clearance has been sought when necessary for some of these tests. The results of these tests are not intended to be used as the sole means of diagnosis or patient management decisions. Additional testing or physician consults may be warranted. You should seek the advice of your physician should you have any questions or concerns about any testing or test results.

5. After removal of your personal identifiers, your sample may be stored for test validation purposes. No clinical tests(s) other than the ones you authorized will be performed.