PGx Pharmacogenetics Test Requisition Form

FIRMALAB
BIO-DIAGNOSTICS

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PATIENT INFORMATION

LAST NAME | FIRST NAME

DATE OF BIRTH (DD/MM/YYYY) | SEX ASSIGNED AT BIRTH ☐ Male ☐ Female ☐ Unknown

ADDRESS

CITY | STATE | ZIP CODE | COUNTRY

ORDERING PROVIDER

INSTITUTION/PRACTICE NAME | INSTITUTION PHONE

PROVIDER LAST NAME | PROVIDER FIRST NAME

NPI (USA)/MINC (CAN) | PROVIDER ADDRESS

CITY | STATE/PROVINCE | POSTAL CODE | COUNTRY

PROVIDER PHONE/FAX | PROVIDER EMAIL

TEST OPTIONS

☐ **Comprehensive Panel**

ABCB1, ABCG2, ADRA2A, ADRB2, ANKK1, APOE, C11orf65, COMT, CYP1A2, CYP2B6, CYP2C, CYP2C8, CYP2C9, CYP2C19, CYP2D6, CYP3A4, CYP3A5, CYP4F2, DPYD, DRD2, EPHX1, F2, F5, GRIK4, HTR1A, HTR2A, HTR2C, ITGB3, MTHFR, NUDT15, OPRM1, SLC6A2, SLCO1B1, TPMT, UGT2B15, VKORC1

DATE/TIME OF COLLECTION: (MM/DD/YYYY): ______________ ______________ ○ AM ○ PM

ICD-10 Codes:

- ☐ F31.9 Bipolar disorder, unspecified
- ☐ F41.9 Anxiety disorder
- ☐ G89.29 Chronic pain
- ☐ GI21.9 Acute myocardial infarction
- ☐ I25.9 Chronic ischemic heart disease
- ☐ E78.5 Hyperlipidemia
- ☐ F33.9 Major depressive disorder, recurrent
- ☐ ____________
- ☐ ____________
- ☐ ____________
- ☐ ____________

Please list any and all applicable ICD-10 Codes below:

____

CLINICAL INFORMATION

MEDICATION	DOSAGE	QUANTITY	FREQUENCY	
______	/ ______	/ ______	/ ______	☐ Previously Prescribed ☐ Currently Prescribed ☐ Considering
______	/ ______	/ ______	/ ______	☐ Previously Prescribed ☐ Currently Prescribed ☐ Considering
______	/ ______	/ ______	/ ______	☐ Previously Prescribed ☐ Currently Prescribed ☐ Considering
______	/ ______	/ ______	/ ______	☐ Previously Prescribed ☐ Currently Prescribed ☐ Considering
______	/ ______	/ ______	/ ______	☐ Previously Prescribed ☐ Currently Prescribed ☐ Considering

APPLICATION OF RESULTS (Check all that apply)

The requested genetic testing is medically necessary for my patient for several reasons.
The primary reason(s) for my request apply specifically to the patient listed below:

- ☐ Determine drug-gene interactions, determining how the patient will metabolize medications
- ☐ Reduce the number of medications that my patient is currently prescribed
- ☐ Aid in determining the potential effectiveness of medications prescribed to my patient
- ☐ Aid in determining the best course of therapy for my patient
- ☐ Avoid toxicity and adverse drug reactions
- ☐ Patient is not responding to the drugs he/she has been prescribed
- ☐ Other

I, the medical provider, will utilize the test results as defined below:

- ☐ Prescribe clinical decision support for prescribing medications.
- ☐ Prescribe clinical decision support for avoiding or removing medications from existing regimen.
- ☐ Prescribe clinical decision support for dosing and titration
- ☐ Prescribe clinical decision support for managing cardiovascular risk.

BILLING INFORMATION

○ **OPTION 1:** Insurance Billing

PRIMARY INSURANCE ID | INSURANCE NAME | STATE | GROUP | INSURANCE PHONE #

INSURANCE PLAN | NAME OF INSURED | RELATION TO PATIENT | DATE OF BIRTH (MM/DD/YYYY)

SECONDARY INSURANCE ID | INSURANCE NAME | STATE | GROUP | INSURANCE PHONE #

INSURANCE PLAN | NAME OF INSURED | RELATION TO PATIENT | DATE OF BIRTH (MM/DD/YYYY)

○ **OPTION 2:** Institutional **OR** ○ **OPTION 3:** Self Pay

INSTITUTION/PAYOR FIRST & LAST NAME NAME | ATTENTION TO

ADDRESS | CITY | STATE/PROVINCE | POSTAL CODE | COUNTRY

PHONE | FAX | EMAIL

Patient Consent:
I am voluntarily seeking laboratory service and hereby consent to provide a sample as requested. I have the right to refuse testing, but I understand this may impact my treatment. This agreement can be revoked by me at any time with written notification and is valid until revoked. I hereby assign to the laboratory my right to insurance benefits that may be payable to me for services provided arising from any insurance policy, self-insured health plan, Medicare or Medicaid in my name or on my behalf. I further authorize payment of benefits directly to the laboratory. I understand acceptance of insurance does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether or not they are covered by my insurance. I understand that any payment I receive for services rendered by the laboratory from my insurance provider should be forwarded to the laboratory immediately.

Patient Signature: ______________________ Date: __________

Physician Certification:
This test is medically necessary for the risk assessment, diagnosis or detection of a disease, illness, impairment, symptom, syndrome or disorder. The results will determine my patient's medical management and treatment decisions. By my signature below, I indicate that I am the referring physician or authorized health care provider. I have explained the purpose of the test. The patient has been given the opportunity to ask questions and/or seek further counsel. The patient has voluntarily decided to have the test performed by Firma Lab Diagnostics Lab. As the medical provider, I am responsible for documenting applicable ICD-10 diagnosis codes.

Provider Signature: ______________________ Date: __________