PROMETHEUS® Anser®

TEST REQUISITION

PLEASE PRINT

PROMETHEUS® Therapeutics & Diagnostics
For the person in every patient®
A Nestlé Health Science Company

SAMPLE COLLECTION INFORMATION

DATE COLLECTED (required):

TIME COLLECTED:

PATIENT ID #:

SENDER SAMPLE ID #:

MEDICARE ONLY - HOSPITAL STATUS WHEN SAMPLE WAS COLLECTED:
☐ Hospital inpatient ☐ Hospital outpatient ☐ Non-hospital patient

LABORATORY/OTHER NAME/ADDRESS:

PHONE #: FAX #:

CONTACT:

RESULTS: ☐ Mail ☐ Fax ☐ No results to lab

PATIENT INFORMATION (REQUIRED)

LAST NAME:

FIRST NAME: MI:

ADDRESS: APT. #:

CITY: STATE: ZIP:

HOME PHONE #: OTHER PHONE #:

DOB: SEX: ☐ M ☐ F SSN #:

BILLING INFORMATION (REQUIRED)

BILL: ☐ Provider account ☐ Insurance ☐ Laboratory ☐ Patient

☐ **Medicare**: We will submit claims to Medicare for most of our services, but only for patients who are neither hospital inpatients nor hospital outpatients, for whom the hospital must submit a claim.

I certify that the ordered test(s) is/are reasonable and medically necessary for the diagnosis, care, and treatment of this patient's condition.

ORDERING PROVIDER'S SIGNATURE: ____________________

PRINT NAME: ____________________ DATE: __________

PRIMARY INSURANCE: As a courtesy, we will bill your insurance. Please attach a copy (front and back) of insurance card(s) and complete all information below. **NOTE: Parent or guardian information is required if patient is a minor. Parent or guardian is responsible for payment.**

NAME OF PARENT OR GUARDIAN (IF PATIENT IS UNDER 18 YEARS OF AGE):

INSURANCE CARRIER: POLICY #:

GROUP NAME: GROUP #:

ADDRESS:

CITY: STATE: ZIP:

PHONE #: FAX #:

POLICYHOLDER NAME:

POLICYHOLDER ID# (SSN):

POLICYHOLDER DOB: RELATION TO PATIENT:

SECONDARY INSURANCE: Attach a copy (front and back) of the secondary insurance card. Provide the insurance name, policy number and group name, billing address and phone, policyholder name, ID#, date of birth, relation to patient, and phone number.

PREAUTH/REFERENCE #: ____________________

PROVIDER/ACCOUNT INFORMATION

ACCOUNT NAME/ADDRESS:

PHONE #: FAX #:

PROVIDER/NPI #:

ICD CODES (required):

CLINICAL DIAGNOSIS: ____________________

REASON FOR ORDER:

☐ Loss of response ☐ Infusion/allergic reaction ☐ Restart after drug holiday
☐ Relapse ☐ Disease monitoring ☐ Side effects

MUST PROVIDE DOSAGE INFORMATION
INFUSION/INJECTION DATE: ______ / ______ / ______

DOSE: __________ mg **or** __________ mg/kg

FREQUENCY: Every ____________________ weeks

ROUTE OF ADMINISTRATION: ____________________

SELECT THE APPROPRIATE TEST TO BE PERFORMED

PLEASE PROVIDE ALL REQUIRED BILLING INFORMATION FOR EACH TEST ORDERED.

☐ PROMETHEUS® **Anser® ADA** - #3170
Simultaneously measures **adalimumab (ADA)** and antibodies to adalimumab (ATA) levels in serum.

☐ PROMETHEUS® **Anser® IFX** - #3150
Simultaneously measures **infliximab (IFX)/infliximab biosimilar** and antibodies to infliximab (ATI) levels in serum.
SELECT MEDICATION: ☐ **REMICADE® (INFLIXIMAB)** ☐ **INFLIXIMAB BIOSIMILAR**
Anser IFX has been validated for use in patients treated with infliximab biosimilars.

☐ PROMETHEUS® **Anser® UST** - #3190
Simultaneously measures **ustekinumab (UST)** and antibodies to ustekinumab (ATU) levels in serum.

☐ PROMETHEUS® **Anser® VDZ** - #3180
Simultaneously measures **vedolizumab (VDZ)** and antibodies to vedolizumab (ATV) levels in serum.

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Specimen collection requirements on back.

ADA17002-NY 09/17

SPECIMEN COLLECTION AND HANDLING PROCEDURES

Test Ordered (Turnaround Time From Date of Receipt)*	Transportation Kit Requirements	Type of Specimen Required	Tube for Specimen Collection	Recommended Specimen Volume	Storage Conditions	Stability of Specimen
PROMETHEUS® Anser® ADA **PROMETHEUS® Anser® IFX** **PROMETHEUS® Anser® UST** **PROMETHEUS® Anser® VDZ** **(3 days)**	Refrigerated preferred, ship with cold pack	SERUM	Serum Separator Tube or Red Top Tube	2.0 mL (0.5 mL for Peds)	Room temperature or refrigerate Do not freeze	Serum is stable for 7 days at room temp or 9 days refrigerated

*Business days.

Specimens should be labeled with 2 identifiers and date of collection. Examples of acceptable identifiers include, but are not limited to, patient name, date of birth, hospital number, and requisition, accession, or unique random number. Unlabeled specimens will not be accepted for testing.

SHIPPING INSTRUCTIONS: Prometheus has an agreement with FedEx Express® for priority overnight delivery service within the United States and Canada. Please call FedEx to schedule a pickup at 1-800-GoFedEx (463-3339). FedEx will pick up your specimens and ship them to Prometheus Laboratories Inc. in San Diego at no expense to you. Prometheus will provide specimen transportation kits upon request.

NOTE: Multiple specimens may be shipped in a single transportation kit.

For more information, call Client Services at 888-423-5227 or go to www.prometheuslabs.com.

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