PROMETHEUS®
Therapeutics & Diagnostics
For the person in every patient®

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www.prometheuslabs.com
A Nestlé Health Science Company

TEST REQUISITION

PLEASE PRINT

Laboratory 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 NAME / ADDRESS

PHONE FAX

CONTACT

RESULTS ☐ Mail ☐ Fax ☐ No results to lab

Patient Information (required)

LAST NAME

FIRST NAME MI

ADDRESS APT. NO.

CITY STATE ZIP

HOME PHONE NUMBER

OTHER PHONE NUMBER

DOB SEX ☐ M ☐ F SSN

Billing Information (required)

BILL: ☐ 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 Physician's Signature Date

Print Name

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 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 NUMBER

GROUP NAME GROUP NUMBER

ADDRESS

CITY STATE ZIP

PHONE FAX

POLICYHOLDER NAME

POLICYHOLDER ID# (SSN)

POLICYHOLDER DOB RELATION TO PATIENT

POLICYHOLDER PHONE

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 Information

ACCOUNT NAME / ADDRESS

PHONE FAX

PHYSICIAN / NPI#

ICD CODES (required)

CLINICAL DIAGNOSIS

PROMETHEUS TESTING ONLY. NO SUBSTITUTIONS.†

CHECK THE APPROPRIATE TEST(S) TO BE PERFORMED
(Specimen collection requirements on back)

IBD

☐ PROMETHEUS® **IBD sgi Diagnostic**™ - #1800*
Includes serology, genetic and inflammation markers to help differentiate IBD vs. non-IBD and Crohn's disease vs. UC
Requires EDTA/Lavender Top Tube and Serum Tube

PROMETHEUS® **IBD sgi Diagnostic Add-On Options**
(by selecting highlighted ADD options below you are ordering Prometheus IBD sgi and a conditional add-on test order)

☐ **ADD** PROMETHEUS® **Crohn's Prognostic** - #2001*
If PROMETHEUS **IBD sgi Diagnostic** indicates Crohn's disease

☐ **ADD** PROMETHEUS® **Celiac PLUS** - #6360*
If PROMETHEUS **IBD sgi Diagnostic** indicates non-IBD

☐ **ADD** PROMETHEUS® **Celiac Genetics** - #6260*
If PROMETHEUS **IBD sgi Diagnostic** indicates non-IBD

☐ **ADD** PROMETHEUS® **Celiac Serology** - #1155
If PROMETHEUS **IBD sgi Diagnostic** indicates non-IBD

☐ PROMETHEUS® **Crohn's Prognostic** - #2001*
Includes serology and genetic markers to provide a patient's risk of future complications from Crohn's Disease

CELIAC

☐ PROMETHEUS® **Celiac PLUS** - #6360*
Includes both antibody and genetic tests with risk stratification

☐ PROMETHEUS® **Celiac Genetics** - #6260 (Genetics only)*
Celiac genetic assessment HLA DQ2/DQ8 with risk stratification

☐ PROMETHEUS® **Celiac Serology** - #1155 (Serology only)
Includes the following:
☐ Tissue transglutaminase (tTG) IgA recombinant antigen - #1405
☐ Anti-endomysial (EMA) IgA - #1505 ☐ Total serum IgA - #1605
☐ DGP IgA - #1255 ☐ DGP IgG - #1355

THIOPURINE MGMT

☐ PROMETHEUS® **TPMT Genetics** - #3300*
Genotype patients for individualized starting dose of thiopurines

☐ PROMETHEUS® **TPMT Enzyme** - #3320
Phenotype patients for individualized starting dose of thiopurines

☐ PROMETHEUS® **Thiopurine Metabolites** - #3200
Thiopurine metabolite (6-TGN, 6-MMPN) levels
Optimize ongoing dosing of thiopurines to reach and maintain therapeutic goal
Current therapeutic: ☐ 6-MP___mg/day ☐ AZA___mg/day ☐ Other___mg/day

ADD'L TESTS

☐ PROMETHEUS® **FIBRO*Spect*® II** - #4000

☐ PROMETHEUS® **Lacto*TYPE*®** - #6100*
Lactose intolerance genetic assessment

☐ Other Prometheus Tests

†By using the Prometheus test requisition, you are specifically requesting that your patient's specimen be sent to Prometheus for testing and asking that no alternative test be performed.

GENETIC CONSENT
*My signature below indicates that I have read and understood the entire consent form on the back page.

Physician Signature: Date:

Patient/Guardian Signature: Date:

SPECIMEN COLLECTION AND HANDLING PROCEDURES

Test Ordered (Turnaround Time from Date of Receipt)*	Specimen Requirements	Recommended Specimen Volume**	Specimen Storage / Stability***	Transportation Kit Requirement
PROMETHEUS® IBD sgi Diagnostic (3-4 days)	SERUM AND WHOLE BLOOD in Serum Separator or Red Top Tube AND EDTA/ Lavender Top Tube	2.0 mL Serum **AND** 2.0 mL Whole Blood	Room temp: 7 days Refrigerated: 21 days	Ambient or cold pack acceptable
PROMETHEUS® Crohn's Prognostic (4-7 days)	SERUM AND WHOLE BLOOD in Serum Separator or Red Top Tube AND EDTA/ Lavender Top Tube	2.0 mL Serum **AND** 2.0 mL Whole Blood	Room temp: 7 days Refrigerated: 7 days	Ambient or cold pack acceptable
PROMETHEUS® Celiac PLUS (PROMETHEUS Celiac Serology and PROMETHEUS Celiac Genetics) **(3 days)**	SERUM AND WHOLE BLOOD in Serum Separator or Red Top Tube AND EDTA/ Lavender Top Tube	2.0 mL Serum **AND** 2.0 mL Whole Blood	Room temp: 7 days Refrigerated: 30 days	Ambient or cold pack acceptable
PROMETHEUS® Celiac Genetics (2-3 days)	WHOLE BLOOD in EDTA/ Lavender Top Tube	2.0 mL Whole Blood	Room temp: 7 days Refrigerated: 30 days	Ambient or cold pack acceptable
PROMETHEUS® Celiac Serology (2-3 days)	SERUM in Serum Separator or Red Top Tube	2.0 mL Serum (0.5 mL for Peds)	Room temp: 7 days Refrigerated: 30 days	Ambient or cold pack acceptable
PROMETHEUS® TPMT Genetics (2 days)	WHOLE BLOOD in EDTA/ Lavender Top Tube	2.0 mL Whole Blood	Room temp: 10 days Refrigerated: 30 days	Ambient or cold pack acceptable
PROMETHEUS® TPMT Enzyme (3 days)	WHOLE BLOOD in EDTA/ Lavender Top Tube	5.0 mL Whole Blood	Room temp: 24 hours Refrigerated: 8 days	Refrigerated preferred, ship with cold pack
PROMETHEUS® Thiopurine Metabolites (3 days)	WHOLE BLOOD in EDTA/ Lavender Top Tube	5.0 mL Whole Blood	Room temp: 3 days Refrigerated: 8 days	Refrigerated preferred, ship with cold pack
PROMETHEUS® FIBROSpect® II (4 days)	SERUM in Serum Separator or Red Top Tube	2.0 mL Serum (0.5 mL for Peds)	Room temp: 7 days Refrigerated: 30 days	Ambient or cold pack acceptable
PROMETHEUS® LactoTYPE® (7 days)	WHOLE BLOOD in EDTA/ Lavender Top Tube	2.0 mL Whole Blood	Room temp: 10 days Refrigerated: 30 days	Ambient or cold pack acceptable

*Business days
**Note: Minimum specimen volume for genetic testing may vary with the WBC count.
***Frozen stability data may be available. Contact Client Services if detailed information is needed.

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, requisition, accession or unique random number. Unlabeled specimens <u>will not</u> 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 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: (888) 423-5227 or go to www.prometheuslabs.com

INFORMED CONSENT FOR GENETIC TESTING

I request and authorize Prometheus to test my/my child's genetic specimen for the test specified on the attached test requisition. The purpose of this test is to determine if I/my child may have a mutation in the gene(s) being tested, which has been found to be associated with this condition. I understand that this test will only test for this specific condition; it will not detect ALL possible mutations within this gene, nor will it detect mutations in other genes.

My doctor has discussed the genetic test ordered and has described the steps involved in the test, the constraints of the procedure, and its accuracy. I have been advised of the risks and benefits of genetic testing. The significance of a positive and a negative test result has been explained to me by a qualified medical professional. I understand that a positive test result is an indication that I may be predisposed to, or have, the condition listed above. If the results are positive, I understand that I may wish to consider further independent testing, consult my physician, or pursue genetic counseling. I understand that the test may fail, that the results may be non-informative or not predictive for my case, and that these tests may reveal information that is unrelated to their intended purpose.

Genetic testing offered at Prometheus is completely voluntary and is used to predict response to specific therapeutics and/or to provide information to aid in the treatment of gastrointestinal ailments. No unauthorized testing is performed on the specimens. I authorize Prometheus to report my test results directly to the ordering physician. The genetic specimens will be destroyed within 60 days of test completion. This consent does not authorize the use or release of any other medical information unrelated to this genetic test.

I understand that I may seek professional genetic counseling prior to signing this informed consent and undergoing the testing procedure, and I have received written information identifying a genetic counselor or medical geneticist by my treating physician.