Prometheus Laboratories | TEST REQUISITION

PLEASE PRINT

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:

ACKNOWLEDGMENT OF INFORMED CONSENT FOR GENETIC TESTING
My signature below indicates that I have read and understand the genetic consent requirement for my patient on the back page and acknowledge that I have obtained the appropriate consent from my patient.

PROVIDER SIGNATURE: _____ DATE: _____

BILLING INFORMATION (REQUIRED)

BILL: ☐ Provider account ☐ Insurance ☐ Laboratory ☐ Patient

☐ **MEDICARE - MEDICAL NECESSITY NOTICE:** When ordering tests for which Medicare reimbursement will be sought, physicians (or other individuals authorized by law to order tests) should only order tests that are medically necessary for the diagnosis or treatment of a patient, rather than for screening purposes.

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: 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 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:
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/ACCOUNT INFORMATION

ACCOUNT NAME/ADDRESS:
Account Name
Address 1
Address 2
City, State, Zip
Country

PHONE #: FAX #:

PROVIDER/NPI #:

ICD CODE(S) (required):

CLINICAL DIAGNOSIS:

PROMETHEUS TESTING ONLY. NO SUBSTITUTIONS.*

SELECT THE APPROPRIATE TEST TO BE PERFORMED

CHECK BOX ON LEFT NEXT TO TEST BEING ORDERED.
SPECIMEN COLLECTION REQUIREMENTS ON BACK.

IBD

☐ **IBD sgi Diagnostic®** - #1800†
(By selecting an ADD option below, you are ordering a conditional add-on test order.)
- ☐ ADD **Monitr™ Crohn's Disease** - #7300
(Conditional order following an IBD sgi result consistent with Crohn's disease.)
- ☐ ADD **RiskImmune™** - #3600†
(Conditional order following an IBD sgi result consistent with Inflammatory Bowel Disease.)

☐ **Monitr Crohn's Disease** - #7300
13 biomarkers to assess endoscopic disease activity in Crohn's disease patients.

☐ **RiskImmune** - #3600† **New**
Aids in predicting risk of antibody formation to infliximab, adalimumab or biosimilars.
(By selecting an ADD option below, you are ordering a conditional add-on test following a RiskImmune result consistent with an increased risk of antibody formation to infliximab or adalimumab.)
- ☐ ADD **TPMT Genetics** - #3300†
- ☐ ADD **TPMT Enzyme** - #3320

☐ **Crohn's Prognostic**-#2001†

☐ **7C4 Diagnostic Test** - #8205

THIOPURINE MGMT

☐ **TPMT Genetics** - #3300†

☐ **TPMT Enzyme** - #3320

☐ **Thiopurine Metabolites** - #3200
Current therapeutic:
☐ 6-MP _____mg/day ☐ AZA _____mg/day ☐ Other _____mg/day

CELIAC

☐ **Celiac PLUS** - #6360†

☐ **Celiac Genetics** - #6260† (genetics only)

☐ **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

LIVER

☐ **FIBRO*Spect*® HCV** - #4000
Assessment of liver fibrosis severity for HCV patients.

☐ **FIBRO*Spect*® NASH** - #4100
Assessment of liver fibrosis severity for NASH patients.

ADD'L TESTS

☐ **Lacto*TYPE*®** - #6100†

☐ Other Prometheus test(s): _____

*By using this 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.

† Acknowledgment of informed consent for NY state.

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SPECIMEN COLLECTION AND HANDLING PROCEDURES

Test Ordered (Turnaround Time From Date of Receipt)[a]	Specimen Requirements	Recommended Specimen Volume[b]	Specimen Storage/Stability[c]	Transportation Kit Requirements
IBD sgi Diagnostic (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
Monitr Crohn's Disease (4 days)	SERUM in **SPUN** Serum Separator Tube	2.0 mL serum	Room temp: 3 days Refrigerated: 14 days	Refrigerated preferred, ship with cold pack
RiskImmune (4 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
Crohn's Prognostic (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
7C4 Diagnostic Test (7 days)	SERUM in Serum Separator or Red-Top Tube	1.0 mL serum	Room temp: 3 days Refrigerated: 7 days	Cold pack required
Celiac PLUS (PROMETHEUS Celiac Genetics and PROMETHEUS Celiac Serology) **(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: 30 days	Ambient or cold pack acceptable
Celiac Genetics (4 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
Celiac Serology (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
TPMT Genetics (4 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
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
Thiopurine Metabolites (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
FIBRO*Spect* HCV FIBRO*Spect* NASH (7 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
Lacto*TYPE* (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

[a]Business days. | [b]Note: Minimum specimen volume for genetic testing may vary with the white blood cell count. | [c]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 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.

ACKNOWLEDGEMENT OF INFORMED CONSENT FOR NEW YORK STATE ONLY

I warrant that this test was ordered and that I have obtained the appropriate prior written consent. This written consent was signed by the person who is the subject of the test (or if that person lacks capacity to consent, signed by the person authorized to consent for that person) and includes the following (unless certain that the following information is not required by the state in which I practice):

1. The purpose of this test is to determine if the patient may have a variant in the gene(s) being tested, which has been found to be associated with this condition.
2. This test will only test for this specific condition and will not detect ALL possible variants within this gene, nor will it detect variants in other genes.
3. Prior to my signature of the written consent, a qualified healthcare professional discussed with the patient the genetic test ordered and described the steps involved in the test, the constraints of the procedure, and its accuracy.
4. My patient was advised by a qualified healthcare professional of the risks and benefits of genetic testing, and advised of the significance of a positive and negative result.
5. The patient understands that a positive test result is an indication that the patient may be predisposed to, or have, the condition listed above.
6. The patient understands that the test may fail, that the results may be non-informative or not predictive for his/her case, and that the test may reveal information that is unrelated to their intended purpose.
7. No unauthorized test is performed on specimens.
8. Specimens will be destroyed within 60 days after collection when no longer required for clinical purposes.
9. The informed consent does not authorize the use or release of any other identified medical information unrelated to this genetic test.
10. The patient understood that he/she could see professional genetic counseling prior to undergoing the testing procedure, and received written information identifying a genetic counselor or medical geneticist by his/her treating provider.

These tests are laboratory-developed tests that were developed and validated under Federal CLIA laboratory guidelines by Prometheus.