DRUG METABOLISM TEST REQUISITION

FAILURE TO COMPLETE ALL REQUIRED FIELDS MAY DELAY PATIENT RESULTS.

2040 Babcock Rd STE#201, San Antonio, Texas, 78229

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CLIA # 45D2116443 Lab Director: Manoj Tyagi, Ph.D.

Sample Information

Collection Date:	Collection Time:	Sample Collected By:	Requisition Completed By:	Accession Number
			for iGenomeDx use	for iGenomeDx use

Physician Information

Physician Name & NPI:	Practice Name:		Office Phone:
Practice Address:	**City:**	**State:**	**Zip Code:**

Ordering Physician/Authorizing Medical Professional Signature: I hereby authorize testing for this patient. I have provided information regarding genetic testing, and the patient has given consent for testing to be performed. I attest that the ICD-10 Diagnosis Codes provided are accurate records and supported by patients records. I attest that these tests are medically necessary. I hereby authorize iGenomeDx Laboratories to send these patient's test results to the patient's third party payer, if needed, to appeal a denial of reimbursement prior to attempts to obtain reimbursement without the release of patient's results. I understand tht each panel test may include a combination of ANKK1, ApoE, COMT, CYP1A2, CYP2B6, CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, FACTOR II, FACTOR V, MTHFR, OPRM1, SLCO1B1 and, VKORC1.

X

Patient Information (Attach patient demographic sheet)

Patient Name: (Last , First)	**PatientDate of Birth:** (MM/DD/YYYY)	Patient Gender: Ethnicity:
Patient Address:	Patient Email:	Phone:

Patient Consent Signature: I authorize the release of my medical information (including genetic test results) for submission of personalized reports to my healthcare providers and insurance carrier(s). I request that payment of benefits be made to iGenomeDx Laboratories on my behalf. If my policy does not allow for direct payment, I agree to relinquish allocated funds to iGenomeDx Laboratories as compensation for services rendered. I also acknowledge that I will be liable for payment of deductible, co-payment and/or co-insurance as detailed by my healthcare insurer. I understand that I am liable for charges not covered by my healthcare insurer. I also authorize iGenomeDx Laboratories to appeal insurance claims on my behalf. I acknowledge the benefits, risks, and limitations of this testing as described to me by a qualified healthcare provider. I understand that my sample may be used for confidential training, quality control and validation purposes.

X

Specimen Type:

X **Buccal Swab**

Test Request

Check the box beside the desired Personalized Pharmacogenomic test, based on patient's medical needs.

☐ **iCompGx** (Comprehensive)	ANKK1, ApoE, COMT, CYP1A2, CYP2B6, CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, FACTOR II, FACTOR V, MTHFR, OPRM1, SLCO1B1 and, VKORC1
☐ **iPainGx** (Pain)	CYP3A4, CYP3A5, CYP2B6, CYP2C9, CYP2C19, CYP2D6 and OPRM1
☐ **iCardioGx** (Cardiovascular)	ApoE, CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, Factor II, Factor V, MTHFR, SLCO1B1 and VKORC1
☐ **iPsychGx** (Psychiatry)	ANKK1, COMT, CYP1A2, CYP2C9, CYP2C19, CYP3A4, CYP2D6, HTR2A, OPRM1 and MTFHR

Diagnosis (ICD-10 Codes)

Please state why this test constitutes medical necessity for the patient. Reimbursement requires all diagnoses to be coded to a higher degree of specificity.

ICD-10 Codes	ICD-10 Codes	ICD-10 Codes

Insurance and Payment

A photocopy of both sides of Patient's insurnace card(s) must be included.

☐ Self Pay ☐ Medicaid

☐ Other ☐ Medicare

Insurance Information

Primary Insurance:

Member ID:	Group Name:	Name of Insurance:	Claims Address:

Secondary Insurance:

Member ID:	Group Name:	Name of Insurance:	Claims Address:

Patient Medication List (Please list or attach patient's current medications)

Informed Consent Information

Submission of a requisition for any test listed on this iGenomeDx Requisition form constitutes acknowledgement by the ordering Phyisican and Patient:

1. Each genetic panel may include a combination of the following tests: ANKK1, COMT, ApoE, CYP1A2, CYP2B6, CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, FACTOR II, FACTOR V, MTHFR, OPRM1, SLCO1B1 and, VKORC1.
2. This Ordering physician has obtained written informed consent for each test ordered, as required by applicable state and federal laws. A copy of the informed consent is not required by iGenomeDx in order to process a sample, but a copy must be available in the ordering physicians record.
3. The patient has provided written authorization for iGenomeDx to report the results of each test directly to the ordering physician.
4. The DNA results may:
   a. Indicate whether the patient is a carrier for a certain condition.
   b. Predict whether another family member is a carrier of a certain condition.
   c. Diagnose whether the patient has a condition, or is at increased risk for developing that condition.
   d. Predict whether another family member has or is at increased risk for developing a condition.
   e. Provide undetermined results due to technical limitations or familial genetic patterns.
5. The DNA test pertains only to a drug metabolism and cardiovascular risk factors, it will not detect all causative gene mutations.
6. The significance of a positive or a negative test result, based on patient's family history, have been explained to the patient.
7. DNA testing usually provides precise information, however, several sources of error are possible. These include, but are not limited to, clinical misdiagnosis of the condition, sample misidentification, and inaccurate information regarding familial relationships.
8. All test results will be released directly to the ordering physician, or on their behalf, as state and local laws allow.
9. iGenomeDx is authorized to perform high complexity testing under the Clinical Laboratory Improvement Amendments (CLIA). The results are not intended to be used as the sole means for clinical diagnosis or patient care decisions.
10. iGenomeDx recommends genetic counseling for the patient prior to as well as after genetic testing.
11. The requested DNA test may contain additional Quality Control (QC) markers that are reviewed and the data retained regarding specific genetic locations. These QC markers may be used for specific QC steps of the testing process. In addition, de-identified, extracted DNA may be used as blinded validation or specimen for research and development. No additional results beyond the genetic test requested and the QC markers will be interpreted on this sample. Once testing and QC are completed, the sample will be destroyed.
12. The Patient acknowledges their right to obtain a copy of their written report as required by state and federal laws.

X Patient Signature

X Date