ACCU REFERENCE MEDICAL LAB®

www.accureference.com | 1901 EAST LINDEN AVE. SUITE 4, LINDEN, NJ 07036 | T: (908) 474-1004 F: (908) 474-0032

PHARMACOGENETIC REQUISITION FORM

PHYSICIAN'S INFORMATION

PATIENT'S INFORMATION

Last Name: _____ First Name _____

M.I. _____ Gender ☐F ☐M DOB ___/___/___ Phone: (___) _____

Address: _____ SSN: ___-___-____

City: _____ State: _____ Zip: _____ Pt. ID _____

SPECIMEN COLLECTION

Date: ___/___/___ Time: ___:___ ☐am ☐pm

Sample Type: Buccal swab

Collected By (Print) _____

BILLING INFORMATION

Insurance Co. Name: _____ Subscriber Member # _____ Group # _____

Insurance Address _____ City: _____ State: _____ Zip: _____

☐ Bill Patient ☐ Bill Client ☐ Bill Insurance

TEST MENU - Check Boxes

5088 ☐ AccuCARDIAC Panel	CYP2C19 CYP2D6 CYP2C9 CYP3A4 CYP3A5 SLCO1B1 APOE VKORC1 LPA ITGB3
5089 ☐ AccuPSYCH Panel	CYP2C19 CYP2D6 CYP2C9 CYP3A4 CYP3A5 CYP1A2 ANKK1/DRD2 COMT HTR2A HTR2C UGT2B15
5087 ☐ AccuPAIN Panel	CYP2C19 CYP2D6 CYP2C9 CYP3A4 CYP3A5 CYP1A2 CYP2B6 OPRM1
5086 ☐ AccuCOMPREHENSIVE Panel	CYP2C19 CYP2D6 CYP2C9 CYP3A4 CYP3A5 CYP1A2 CYP2B6 SLCO1B1 APOE VKORC1 ANKK1/DRD2 OPRM1 COMT HTR2A HTR2B LPA ITGB3 UGT2B15
5090 ☐ CYP2C9/VKORC1	CYP2C9 VKORC1
5092 ☐ CYP2D6	CYP2D6
5091 ☐ CYP2C19	CYP2C19

CUSTOM PROFILES / ADDITIONAL GENES

Y435 ☐ CYP2C9	Y445 ☐ CYP3A5	Y455 ☐ CYP2B6	Y469 ☐ APOE	Y461 ☐ OPRM1	Y493 ☐ HTR2A	Y499 ☐ LPA	Y503 ☐ UGT2B15
Y433 ☐ CYP3A4	Y453 ☐ CYP1A2	Y463 ☐ SLCO1B1	Y467 ☐ ANKK1	Y475 ☐ COMT	Y495 ☐ HTR2C	Y501 ☐ ITGB3	Y465 ☐ VKORC1

ICD-10 CODES

☐	I25.10	Atherosclerotic heart disease of native coronary artery without angina pectoris	☐	F31.5	Bipolar disorder, current episode depressed, mild of moderate severity, unspecified
☐	I25.1107	Atherosclerotic heart disease of native coronary artery with unstable angina pectoris	☐	F31.60	Bipolar disorder, current episode mixed, unspecified
☐	I25.5	Ischemic cardiomyopathy	☐	F33.1	Major depressive disorder, recurrent, moderate
☐	I25.6	Silent Myocardial ischemia	☐	F33.2	Major depressive disorder, recurrent severe without psychotic features
☐	I25.720	Atherosclerosis of autologous artery coronary artery bypass graft(s) with unstable angina pectoris.	☐	F33.3	Major depressive disorder, recurrent severe with psychotic features
☐	I25.9	Chronic Ischemic heart disease, unspecified	☐	F33.9	Major depressive disorder, recurrent unspecified
☐	I66.8	Occlusion and stenosis of other middle cerebral artery	☐	F40.9	Phobic anxiety disorder, unspecified
☐	Z79.02	Long term (current) use of antithrombortics/antiplatelets	☐		
☐	F31.30	Bipolar disorder, current episode depressed, mild of moderate severity, unspecified	☐		
			☐		

CURRENT MEDICATIONS

PATIENT AUTORIZATION

I authorize the collection of this specimen for the purpose of analytical testing by Accu Reference and release of results to my treating physician and staff. I authorize Accu Reference and or ils designees to obtain insurance and billing information and release of such information as necessay to determine and collect benefits. I understand I am financially responsible for payments should Insurance be denied, partially paid, or co-payments required.

Patient Siganture: _____ Intials _____ Month _____ Day _____ Year _____

LETTER OF MEDICAL NECESSITY

Dear Insurance Representative: _____

My patient, _____, has several medical conditions requiring prescription drugs. Given the conditions and drugs being used, testing for drug metabolism and/or certain genetic risk factors is medically necessary. These indications are clearly documented in the paperwork and supporting documentation provided to the laboratory at the time of test requisition.

I ordered the test for this patient in order to understand possible dangers and risks for suboptimal outcomes for specific medications currently prescribed or under consideration.

Specifically to assess:

- ❑ High potential for experiencing adverse drug reaction and episodic events
- ❑ High potential for experiencing thromboembolism, hyperhomocysteinemia and hyperlipidemia
- ❑ Efficacy of current and/or future drug therapy
- ❑ Drug therapy best matched to patient's metabolic genotype/phenotype
- ❑ Correct dosage(s) to maximize therapeutic effect.
- ❑ Other: _____

TREATMENT PLAN STATEMENT _____

I plan to use the information to improve treatment care through the following:

- ❑ Identify current medications that may be causing adverse reactions, such as
- ❑ Identify and prescribe new medications that will provide maximum therapeutic effect without also causing harmful adverse reactions.
- ❑ Determine the optimal dosage(s) for current or potential future medications to ensure maximum effect.
- ❑ Other: _____

CONFIRMATION OF MEDICAL NECESSITY/INFORMED CONSENT

I am requesting that Accu Reference Medical Lab, LLC perform a test(s) for the indications provided on this requisition form. I confirm that the patient has been supplied information regarding genetic testing and the patient has given consent for genetic testing to be performed. I confirm that this test is medically necessary for the diagnosis or detection of a disease, illness, impairment, syndrome or disorder, and that these results will be used in the medical management and treatment decisions for this patient.

Physician Signature _____ Date **MONTH** ___ **DAY** ___ **YEAR** _____

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PGX Self – Pay Patient Agreement

Patient's Name (please print) _____

Insured/Guarantor Name _____

Insurance company _____

Member ID Number _____

This form serves to make you aware that your insurance company, _____ , may not pay for the service(s) described below. The fact that they may not pay for a particular service does not mean that you should not receive it. There is a good reason that your healthcare provider has recommended it.

TEST CODE	DESCRIPTION	PRICE
☐ 5088	ACCU Cardiac Panel	$250.00
☐ 5089	ACCU Psych Panel	$250.00
☐ 5087	ACCU Pain Panel	$250.00
☐ 5086	ACCU Comp Panel	$300.00

TEST CODE	DESCRIPTION	PRICE
☐ 5090	CYP2C9 /VKORC1	$250.00
☐ 5092	CYP2D6	$250.00
☐ 5091	CYP2C19	$250.00

Doctor's Note: _____

Charges may not be covered for the following reason(s):

- It is a non-covered item or service, your insurance company will not pay for it
- The service is considered experimental or for research use and is not covered
- Other (explain): _____

Patients without any health insurance coverage must pay $300 for Genetic testing.

☐ At this time I have no health insurance coverage. I understand that I am responsible for paying all the charges for the lab services performed.

☐ I received the self-pay agreement policy from Accu Reference Medical Lab. I have read and fully understand the information provided to me.

☐ If I have any questions about my charges, statements or balance due, I understand that I many contact **Accu Reference's Billing Department at 908-474-1004.**

Patient signature _____ Date ___/___/___