Gene Street Laboratories

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T 832-478-9955 F 713-903-7916
genestreet.com

Pharmacogenomics Test Requisition

1. PATIENT INFORMATION (REQUIRED)

Please attach a copy of patient demographic sheet

First Name____________________ Last Name______________________
DOB (mm/dd/yyyy) _________________ ☐Male ☐Female Age______
Address____
City_____________________ State________ Zip Code _______________
Phone ____________________ Email_______________________________

2. PATIENT PAYMENT OPTIONS

☐ **INSURANCE: Please attach a copy of front and back of insurance card**

☐ **SELF-PAY:** Gene Street Laboratories will contact patient to obtain payment

☐ **CLIENT BILL OR INSTITUTION BILL**

3. ETHNICITY

☐ African American/Black	☐ French Canadian	☐ Sephardic Jewish
☐ Ashkenazi Jewish	☐ Hispanic	☐ South East Asian
☐ Asian	☐ Pacific Islander	☐ Mixed Race
☐ Caucasian/White	☐ Mediterranean	☐ Unknown
☐ East Asian	☐ Native American	☐ Other

4. ORDERING PHYSICIAN INFORMATION (REQUIRED)

First Name_________________ Last Name______________________________
Medical Credentials_____________ NPI#_______________________________
Facility Name____
Address____
City__________________________ State________ Zip__________________
Name of Office Contact ____
Telephone: ____

5. SPECIMEN INFORMATION (REQUIRED)

Date of Collection_________________ Collected By_______________

Specimen Type **X** Buccal/Cheek Swab

6. CURRENT MEDICATIONS

List ALL medications patient is currently taking and attach a printed copy of all know medications for drug-drug interactions and adverse drug reaction risk

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7. PLEASE COMPLETE THE PATIENT MEDICAL HISTORY SECTION ON THE REVERSE SIDE OF THIS FORM

8. ICD-10 DIAGNOSIS CODE(S)

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9. TEST REQUESTED

☐ **COMPREHENSIVE PHARMACOGENOMICS – 30 Genes** ABCB1, ABCG2, ANKK1, APOE, C11orf65, COMT, CYP1A2, CYP2B6, CYP2C8, CYP2C9, CYP2C19, CYP2D6, CYP3A4, CYP3A5, CYP4F2, DPYD, DRD2, Factor II, Factor V, GRIK4, HTR2A, HTR2C, ITGB3, MTHFR, NUDT15, OPRM1, SLCO1B1, TPMT, UGT2B15, VKORC1

☐ **ANESTHESIA-MALIGNANT HYPERTHERMIA SUSCEPTIBILITY NGS Panel – 2 Genes** CACNA1S, RYR1

☐ **CARDIOVASCULAR – 14 Genes** APOE, CYP2C9, CYP2C19, CYP2D6, CYP3A4, CYP3A5, CYP4F2, Factor II, Factor V, ITGB3, MTHFR, OPRM1, SLCO1B1, VKORC1

☐ **ONCOLOGY - 8 Genes** CYP2C8, CYP2C19, CYP2D6, CYP3A4, MTHFR, NUDT, SLCO1B1, TPMT

☐ **PAIN – 10 Genes** ABCB1, ANKK1, COMT, CYP1A2, CYP2B6, CYP2C9, CYP2C19, CYP2D6, CYP3A4, OPRM1

☐ **PSYCHIATRY – 14 Genes** ABCB1, ANKK1, COMT, CYP1A2, CYP2B6, CYP2C9, CYP2C19, CYP2D6, CYP3A4, GRIK4, HTR2A, HTR2C, MTHFR, UGT2B15

☐ **WOMEN'S HEALTH- 4 Genes** Factor II, Factor V, CYP2C19, MTHFR

☐ **CUSTOM GENE(S)**

10. PATIENT INFORMED CONSENT

Pharmacogenomics uses information about a person's genetic makeup, to choose medications and medication doses that are likely to work best for that particular person. Depending on your genetic makeup, some drugs may work more or less effectively for you than they do in other people. Likewise, some drugs may produce more or fewer side effects in you than in someone else. Information about your genetic makeup can assist your doctor in prescribing medicines that are most likely to work for you and avoid the trial-and-error approach of giving you various drugs that are not likely to work for you until finding the right one. This test may also help your physician make critical adjustments to the dosages of certain medications, as well as avoid prescribing combinations of drugs that may cause you to experience an adverse reaction. A sterile swab is used to collect cells from the surface of the skin inside of your cheek. This collection is non-invasive and is not associated with any known risk. This swab will be sent to GeneStreet for analysis. Results containing your pharmacogenetic information which may help your doctor understand how you may respond to different medications are sent directly to your healthcare provider who may use those results to create a personalized treatment plan. Pharmacogenomic testing is highly accurate, however testing may yield uninterpretable results for the following reasons: 1) sample contamination, 2) insufficient sample collection, 3) incomplete knowledge of the available genetic markers, 4) technical reasons. The Genetic Information Nondiscrimination Act (GINA) generally protects you against discrimination based on your genetic information when it comes to health insurance and employment. Your results will be released to clinicians directly involved in your care. Your results are confidential to the extent required by law, and may only be released to other medical professionals with your written consent.

By signing below, I, the patient, confirm that I have been informed about the details of the test(s) ordered for me by my provider. I have read the informed consent and I give permission to GeneStreet to perform laboratory testing as described. I understand the risks, benefits and limitations of testing and I voluntarily consent to testing. I authorize GeneStreet to act as my Authorized Representative in requesting a prior authorization, appeal or documents from my health insurance carrier regarding the above-noted service or proposed service and to inform my health plan of my test result only if required for preauthorization or payment of test(s) ordered or additional reflex testing. I understand that I am responsible for all co-pays, deductibles, and amounts not covered by my insurance. I also authorize the release of my medical information necessary to process this claim. I understand that genetic testing not performed by this laboratory will be forwarded to another accredited reference laboratory. I understand and agree that my leftover specimen and clinical information may be used, without information directly identifying me, for research, education, and other business purposes of GeneStreet (each a "secondary use" and together "secondary uses"). I understand that this may involve GeneStreet sharing my leftover specimen and clinical information with other third parties. My leftover specimen and clinical information will be assigned a unique code before any secondary uses. My name or other personal identifying information will not be used in or linked to my specimen and clinical information when they are shared with third parties unless I explicitly authorize that disclosure. I understand that GeneStreet, itself or through its contractors on its behalf, may contact me at a later date regarding my interest in participating in other research activities, including contributing additional clinical information or specimens for use in such activities and/or authorizing the use of my deidentifiable information for secondary uses. I understand and agree that this authorization and consent is voluntary.

Patient Signature ____ **Date** ______________________________

11. CONFIRMATION OF INFORMED CONSENT AND MEDICAL NECESSITY (Please complete reverse side of this form)

The tests ordered are medically necessary for the risk assessment, diagnosis or detection of a disease, illness, impairment, symptom, syndrome or disorder. The results will determine this patient's medical management and treatment decision as indicated in the medical necessity document provided on the reverse side of this form. The person listed as the Ordering Physician is legally authorized to order the test(s) requested herein. The patient was provided with information about the risks and benefits of genetic testing and has consented to genetic testing. Medical necessity is provided on the back of this form.

Ordering Physician Signature ______________________________________ **Date** ______________________________

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12. PATIENT MEDICAL HISTORY

Patient Last Name_______________________________ Patient First Name __________________________________ Middle Initial _________

Date of Birth ___________________________________ Sex ☐ Male ☐ Female

REASON(S) FOR TESTING

This section provides medical necessity documentation for the Pharmacogenomics Tests ordered for this patient.

Select the primary reason(s) for test requested:

☐ The patient is initiating therapy within the drug class of cardiology, psychiatry, pain management.
☐ The patient has ACS, undergoing PCI and is initiating or reinitiating Clopidogrel (Plavix) therapy.
☐ The patient is taking antithrombotic medications (e.g., Clopidogrel).
☐ The patient is taking cardiovascular medications such as beta-blockers, antiarrhythmic drugs, or statins.
☐ The patient is initiating therapy with amitriptyline or nortriptyline for treatment of depressive disorders.
☐ The patient is initiating therapy with tetrabenazine doses greater than 50 mg/day, or re-initiation of therapy with doses greater than 50 mg/day.
☐ The patient is taking psychiatric or neurological drugs (e.g., antidepressants, antipsychotics, anticonvulsants, mood stabilizers, or stimulants).
☐ The patient is prediabetes, has an HbA1c outside the normal range, has a risk of developing diabetes, or has diabetes.
☐ The patient is starting on oral contraceptives (drospirenone/ethinylestradiol) associated with a risk of venous thrombosis.
☐ The patient has a history of medication failure.
☐ The patient is starting a new medication, with no previous history.
☐ The patient has a new diagnosis, with no pharmacological treatment history to treat that diagnosis.
☐ The patient has a history of, or is currently experiencing, adverse side effects from his/her current medication(s).
☐ The patient is on multiple medications, raising the risk for adverse drug reactions.
☐ Dosing increases on current medications have had a sub-therapeutic response.
☐ The patient has not complied with his/her current medication regimen due to adverse drug reactions.

MEDICAL NOTES

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The test results are necessary to:

☐ Guide decisions about which medications to prescribe and/or avoid for this patient, or to guide decisions concerning dosing for current medication(s).
☐ Identify possible alternative medications which may yield a better therapeutic response for this patient than he/she is currently experiencing.
☐ Identify medications that should be avoided due to elevated risk of adverse effects for this patient.
☐ Help manage this patient’s cardiovascular or thrombotic risk.

Physician Signature ____ Date ___________________________________