ALPHA GENOMIX LABORATORIES
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PGT Requisition Form

Clinic Name | Requesting Physician | Today's Date & Time | Collected By

PATIENT INFO

REQUIRED: Enclose a copy of the front and back of patient's insurance card(s), driver's license, and patient demographic.

Last Name | First Name | Middle Initial | Date of Birth | Sex ◯ Male ◯ Female

Address | City | State | Zip | Phone

Ethnicity ◯ African-American ◯ Caucasian ◯ Asian ◯ Hispanic ◯ Other

Have you ever had a Pharmacogenetic test before? ◯ No ◯ If Yes, please attach results.

PAYMENT INFO

Must provide a copy of Front & Back of Insurance Card.

◯ Medicare ◯ Medicaid ◯ Self Pay ◯ Direct Bill

◯ Insurance → Preauthorization Required? ◯ No ◯ Yes PA#

(If preauthorization required, preauthorization # must be present when swab is collected.)

CURRENT MEDICATIONS

Please list any medications that you are taking below.

ICD-10 DIAGNOSIS CODE(S)

Insurance companies require patient specific icd-10 codes to determine medical necessity.

REPORT TYPE

Select one or more.

◯ Standard ◯ DDI Included ◯ Include Psych Risk Factors

TEST REQUESTED

◯ **Personalized Medicine Panel**

CYP1A2, CYP2B6, CYP2C8, CYP2C9, CYP2C19, CYP2D6, CYP3A4, CYP3A5, ABCB1, ADRA2A, ANKK1, APOE, COMT, DPYD, DRD2,Factor II, Factor V Leiden, G6PD, MTHFR, OPRK1, OPRM1, SLC6A4, SLCO1B1, SULT4A1, TPMT, UGT1A1, UGT2B15, VKORC1

◯ **Specialty Panel**

- ☐ **ChemoTox** *(DPYD, MTHFR, TPMT, UGT1A1 and CYPs: 2C8 and 2D6)*
- ☐ **Cardiology & Thrombophilia** *(ABCB1, APOE, Factor II, Factor V Leiden, MTHFR, SLOC1B1, VKORC1 and CYPs: 3A4, 3A5, 2C9, 2C19 and 2D6)*
- ☐ **Pain/Psychiatry** *(ABCB1, ADRA2A, ANKK1/DRD2, COMT, MTHFR, OPRM1, SLC6A4, SULT4A1, UGT2, and CYPs: 1A2, 3A4, P3A5, 2B6, 2C9, 2C19 and 2D6)*

◯ **Single Gene Test** _____

Patient Signature _____ **Date** _____

Physician Signature _____ **Date** _____

Last Updated November 6, 2017

No tests other than the specific DNA tests ordered shall be performed on the biological sample and the sample shall be destroyed no more than sixty days after the sample was taken, unless a longer period of retention is expressly authorized in a separate consent form.

I, the undersigned, understand that I am responsible for all co-pays and deductibles, and for amounts not covered by insurance. By signing this authorization, I am acknowledging that payment(s) be made on my behalf to Alpha Genomix for any services provided to me by Alpha Genomix. I also allow the release of any medical information necessary to process this claim.

I authorize the above ordered laboratory test(s). If no profile or multiple profiles are selected, Alpha Genomix will test the Personalized Medicine Panel.