IntelligeneCG®
Cancer Genomics

BARCODE LABEL

Drug Metabolism Requisition Form

Date received in lab: ___/___/_____

Client / Ordering Provider Information

Name | NPI #

Address

City | State | ZIP

Phone | FAX

Email

Patient Information (Or Affix Patient Sticker)

Name | DOB

Gender ❑ Male ❑ Female | Phone

Address

City | State | ZIP

E-mail

Specimen Information

Date of Collection (MM/DD/YY)

Specimen Type ❑ Buccal Swab ❑ Saliva Collector

Conditions And Pharmaceutical Classes

(For a complete pharmaceutical drug & corresponding gene list - see attached list)

❑ Drug Metabolism - Complete Panel

❑ PSYC Psychiatric Panel (33 genes)

ABCB1, ADRA2A, BDNF, CES1, COMT, CYP1A2, CYP2B6, CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, CYP2E1, DRD1, DRD2, DRD3, DRD4, GRIK1, GRIK4, HLA-A , HLA-B, HTR2A, MC4R, MTHFR, OPRM1, SLC6A2, SLC6A3, SLC6A4, RYR1, UGT1A1, UGT2B15, UGT1A4, 5HT2C.

❑ PEDS Pediatrics Panel (25 genes)

ABCB1, ADRA2A, BDNF, CFTR , COMT, CYP1A2, CYP2B6, CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, CYP2E1, DRD3, HLA-A ,HLA-B, HTR2A, MTHFR, RYR1, SLC6A2, SLC6A3, SLC6A4, TPMT, UGT1A1, VKORC1

❑ Cardiovascular Panel (16 genes)

ABCB1, ABCG2, CYP1A2, CYP2B6, CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, CYP2E1, Factor II, Factor V, MTHFR, RYR1, SLCO1B1, VKORC1.

❑ COMP Comprehensive Panel (41 genes)

ABCB1, ABCG2, ADRA2A, BDNF, CES1, CFTR, COMT, CYP1A2, CYP2B6, CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, CYP2E1, DPYD, DRD1, DRD2, DRD3, DRD4, Factor II, Factor V, GRIK1, GRIK4, HLA-A , HLA-B, HTR2A, MC4R, MTHFR, OPRM1, RYR1, SLC6A2, SLC6A3, SLC6A4, SLCO1B1, TPMT, UGT1A1, UGT2B15, UGT1A4, VKORC1, 5HT2C

❑ Add-on genes

- ❑ ACE
- ❑ ATIC
- ❑ CYP2C8
- ❑ DHFR
- ❑ G6PD
- ❑ HLA-DRB3
- ❑ IFNL3
- ❑ KCNH2
- ❑ MTR
- ❑ SHMT1
- ❑ SLC19A1
- ❑ TYMS

Billing Information *Verification*

Please provide a legible photocopy of the front & back of the insurance card:

Insurance Company | Relationship to patient | ZIP

Insured ID | Group | Address of subscriber (if different than patient)

Name of subscriber

City | State

Benefit and Pricing Verification

I, _____, am providing consent to perform the genetic testing as ordered. I understand that by signing this section:

If I am covered by insurance, I authorize IntelligeneCG and their contracted billing company to give my insurance carrier the information on this form and provided by my healthcare provider that is necessary for reimbursement. I understand that I am responsible for deductible and coinsurance amounts as indicated by my insurance carrier. I agree to assist in resolving insurance claim issues and if I don't assist, I may be responsible for the full cost of the test. I understand that I am responsible for sending IntelligeneCG any and all of the money that I receive directly from my insurance carrier in payment for this test. In addition, if a test is reimbursed by the insurance company for any portion of the cost, IntelligeneCG will not invoice me or hold me responsible for any amount owed above and beyond what has been reimbursed by the insurance company and the cost of the test would be considered paid in full.

If the test is not authorized by or is not covered by my insurance, then I agree to be considered as a Self-Pay patient and will be responsible for the maximum out of pocket cost of the test of $375. IntelligeneCG is authorized to bill me directly for the cost, which shall not exceed the maximum out of pocket of $375. ICG will allow me, at my own choice, to pay for the cost over a maximum of 3 installments if needed. I understand that if payments or arrangements are not made after 3 statements my information may be sent to collections.

I also give my permission for my sample and clinical information to be used for research purposes by IntelligeneCG and for publications. My name or other protected health information will not be used or linked to the results of any research or publications.

❑ **Please check this box to opt out of research studies.**

IntelligeneCG is committed to support you with your share of costs. If required, you will be contacted by our team to setup a payment plan for your portion of the costs using the following forms of payment: Check, Visa, Master Card and American Express. You may also contact our billing team at 913-258-2300.

Signature | Date

Is the patient experiencing: ❑ Adverse effects ❑ Treatment resistance or failure ❑ Abnormal drug screen

MEDICATION LIST, CLINICAL NOTES AND ADVERSE DRUG REACTIONS OR INEFFICACY MUST BE PROVIDED

Reasons for testing this patient (check all that apply)

❑ Drug intolerance and side effects	❑ Treatment resistence and lack of efficacy
❑ Treatment with multiple medications	❑ Elderly or infirm vulnerable patient
❑ Multiple medical conditions or hospitalization	❑ Family history of drug side effects
❑ History of Trombosis, DVT, Embolism, VTE	❑ Hypercoagulable state

How the results will affect the standard of care of this patient? (check all that apply)

❑ Selection of new prescription medication(s)	❑ Discontinuation of existing medication(s)
❑ Alternative dosing for existing medication(s)	❑ Adjustment of current multi-drug regimen
❑ Anti-coagulant, anti-thrombolic treatment	❑ Clarification of prior equivocal diagnostics

Describe current or recommended treatment (frequency and dosage).....

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Duration of treatment.....

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Considered medication(s) (frequency and dosage).....

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Letter of medical necessity and clinical utility (to be filled by ORDERING PROVIDER)
MOST COMMON ICD-10 CODES. PLEASE SELECT ALL THAT APPLY

Considered medication(s) (frequency and dosage).....

❑ F11.20 ❑ F31.9 ❑ F32.1 ❑ F32.2 ❑ F32.3 ❑ F32.4 ❑ F32.9 ❑ F33.1 ❑ F33.2 ❑ F33.3 ❑ F33.9 ❑ F41.1
❑ F41.9 ❑ F90.2 ❑ G89.4 ❑ I20 ❑ I20.1 ❑ I20.8 ❑ I24.8 ❑ I24.9 ❑ I25.110 ❑ I25.111 ❑ T50.905A
❑ T88.7XXA

Other: .....

Ordering Physician's Signature

Ordering provider	NPI #
Signature	Date