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	
Patient ethnicity ❑ African american ❑ Asian ❑ Caucasian	
❑ Hispanic ❑ other	

Specimen Information

Date of Collection (MM/DD/YY)	Specimen Type ❑ Buccal Swab ❑ Saliva

PGX Panels

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

PGx

❑ **PGx CARDIAC PANEL**
CYP2C19 / CYP2C9 / CYP2D6 / CYP3A4 / CYP3A5 / Factor II / Factor V Leiden / MTHFR / SLC01B1 / VKORC1

❑ **PGx COMPREHENSIVE**
ANKK1 / COMT / CYP1A2 / CYP2B6 / CYP2C19 / CYP2C9 / CYP2D6 / CYP3A4 / CYP3A5 / Factor II / Factor V Leiden / MTHFR /OPRM1 / SLC01B1 / VKORC1

❑ **PGx PAIN MANAGEMENT PANEL**
ANKK1 / COMT / CYP1A2 / CYP2B6 / CYP2C19 / CYP2C9 / CYP2D6 / CYP3A4 / CYP3A5 / OPRM1

❑ **PGx PERIOPERATIVE PANEL**
CYP2C19 / CYP2C9 / CYP2D6 / Factor II / Factor V Leiden / MTHFR / OPRM1 / VKORC1

❑ **PGx PSYCHIATRY PANEL**
ANKK1 / COMT / CYP1A2 / CYP2B6 / CYP2C19 / CYP2C9 / CYP2D6 / CYP3A4 / CYP3A5 / MTHFR

Billing Information *Verification*

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

Insurance Company		Relationship to patient
Insured ID	Group	Address of subscriber (if different than patient)
Name of subscriber		
		City / State / ZIP

Benefit and Pricing Verification

I, _____, understand that by signing this section, I am providing consent to IntelligeneCG to perform the genetic testing as ordered. I attest that I am covered by insurance and 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 deductibles 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. If prior authorization is required, I understand that IntelligeneCG or their contracted billing company will call me with the result of the prior authorization. If the result is that the test is not approved during prior authorization then I will have the option to cancel the test at that time.

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.**

Patient signature	Date

Letter of medical necessity and clinical utility (**to be filled by ORDERING PROVIDER**)

ICD-10 codes.....

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Current Medication(s) and Dosage (required).....

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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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Ordering Physician's Signature

Ordering provider	NPI #
Signature	Date