CLIA# 49D2178444 Laboratory Director: Dr. Shamaladevi Nagarajarao, Ph.D
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PLEASE ATTACH DETAILED MEDICAL RECORDS, INSURANCE CARD FRONT/BACK, AND CLINICAL INFORMATION TO THE REQUISITION FORM.

PHARMACOGENOMICS(PGx)

COMPLETE ENTIRE FORM AND SUBMIT PEDIGREE/CLINIC NOTES TO AVOID DELAYS

PERSONAL INFORMATION*

*First Name | Middle Name

*Last Name

*Date of Birth: MM / DD / YYYY

*Address:

*City: | *State: | *Zip:

*Mobile No: | *Social Security:

***Gender:** ○ Male ○ Female ○ Others

***Required** ☐ Ancestry ☐ Asian ☐ Black/African American
☐ White/Caucasian ☐ Ashkenazi Jewish ☐ Hispanic
☐ Native American ☐ Pacific Islander ☐ Other

SPECIMEN INFORMATION* (For Phlebotomist service, select all services you are requesting)

☐ Buccal Swab | Medical Record#

***Collection Date** | ***Collected By** | **Specimen ID**

☐ Specimen is post - mortem | Date of death: MM / DD / YYYY

Account Information*

*Practice Name:

*Date: MM / DD / YYYY | *Phone Number:

*Physician: | *NPI:

*Address:

*City: | *State: | *Zip:

Items Required To Be Submitted With Testing Requisition

☐ Medical Necessity Statement ☐ Medical Records/Notes ☐ Medication List ☐ Insurance Card ☐ Patient Consent ☐ Patient Questionnaire

Name:	Name:	Name:
Date Of Birth: MM / DD / YYYY	Date Of Birth: MM / DD / YYYY	Date Of Birth: MM / DD / YYYY
Date: MM / DD / YYYY	Date: MM / DD / YYYY	Date: MM / DD / YYYY

☐ **INSURANCE BILLING** (Include copy of both sides of insurance card)

Patient Relation to Policy Holder? ☐ Self ☐ Spouse ☐ Child

Insurance Company | Policy# | HMO Auto#

Out of Pocket: We will start testing immediately unless you check the box below. We will attempt to contact you if estimated out-of-Pocket costs are > USD $100.

☐ Do not start testing until I approve payment terms regarding estimated out-of-pocket costs Patient agrees to contact regarding out-of-pocket amount by:

☐ Email ☐ Phone (includes tests) - confirm mobile # ....

Special Billing Notes:

☐ **INSTITUTIONAL BILLING*** ☐ **SELF-PAY**

*Facility Name | ☐ Send Invoice to facility Address above

***Address**

***Contact Name**

***Phone Number**

***E-mail** | **Fax**

☐ PATIENT PAYMENT | ☐ Check (Payable To) ☐ Credit Card

STOP PATIENT CONSENT (SIGNATURE)

I hereby assign all rights and benefits under my health plan and all rights and obligations that I and my dependents have under my health plan to MicroGen Health its assigned affiliates and authorized representatives for laboratory services furnished to me by MicroGen Health. I irrevocably designate, authorize and appoint MicroGen Health or its assigned affiliates and their authorized representatives as my true and lawful attorney-in-fact for the purpose of submitting my claims, obtain a copy of my health plan document, summary plan description, disclosure, appeal, litigation or other remedies in accordance with the benefits and rights under my health plan and in accordance with federal or state laws. If my health plan fails to abide by my authorization and makes payment directly to me, I agree to endorse the insurance check and forward it to MicroGen Health immediately upon receipt. I hereby authorize MicroGen Health its assigned affiliates and authorized representatives to contact me or my health plan/administrator for billing or payment purposes by phone, text message, or email with the contact information that i have provided to MicroGen Health, in compliance with federal and state laws. MicroGen Health, its assigned affiliates and their authorized representatives may release to my health plan administrator, my employer, and my authorized representative my personal health information for the purpose of procuring payment of MicroGen Health and for all the laboratory services. I understand the acceptance of insurance does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether or not they are covered by my insurance.

I have read the Informed Consent document and I give permission to MicroGen Health to perform genetic testing as described.
If you are a New York state resident and give permission for MicroGen Health to retain any remaining sample longer than 60 days after the completion of testing.
By signing above, the patient or payor authorizes MicroGen Health to contact them directly, and use the provided billing instructions to bill the indicated method.

*Patient Signature		*Date: MM / DD / YYYY

☐ **By Checking this box, the ordering provider certifies that the patient cannot physically Sign the Release and Consent**

*Parent/Guardian signature	*Name:	*Date: MM / DD / YYYY

PHARMACOGENOMICS(PGx) FORM

ICD-10 DIAGNOSIS CODES

- ☐ F41.9 - ANXIETY DISORDER, UNSPECIFIED
- ☐ I25.10 - ATHSCL HEART DISEASE OF NATIVE CORONARY ARTERY W/O ANG PCTRS
- ☐ F32.9 - MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, UNSPECIFIED
- ☐ I82.0 - BUDD-CHIARI SYNDROME
- ☐ I82.1 - THROMBOPHLEBITIS MIGRANS
- ☐ Z79.02 - LONG TERM (CURRENT) USE OF ANTITHROMBOTICS/ANTIPLATELETS
- ☐ I82.91 - CHRONIC EMBOLISM AND THROMBOSIS OF UNSPECIFIED VEIN
- ☐ I81 - PORTAL VEIN THROMBOSIS
- ☐ F42.9 - OBSESSIVE-COMPULSIVE DISORDER, UNSPECIFIED
- ☐ F31.9 - BIPOLAR DISORDER, UNSPECIFIED
- ☐ F33.9 - MAJOR DEPRESSIVE DISORDER, RECURRENT, UNSPECIFIED
- ☐ I25.9 - CHRONIC ISCHEMIC HEART DISEASE, UNSPECIFIED
- ☐ Z51.81 - ENCOUNTER FOR THERAPEUTIC DRUG LEVEL MONITORING
- ☐ F32.2 - MAJOR DEPRESSV DISCORD, SINGLE EPSD, SEV W/O PSYCH FEATURES
- ☐ Z85.3 - PERSONAL HISTORY OF MALIGNANT NEOPLASM OF BREAST
- ☐ I13.10 - HYP HRT & CHR KDNY DIS W/O HRT FAIL, W STG 1-4/UNSP CHR KDNY
- ☐ F33.1 - MAJOR DEPRESSIVE DISORDER, RECURRENT, MODERATE
- ☐ I25.110 - ATHSCL HEART DISEASE OF NATIVE COR ART W UNSTABLE ANG PCTRS
- ☐ F31.60 - BIPOLAR DISORDER, CURRENT EPISODE MIXED, UNSPECIFIED
- ☐ F41.1 - GENERALIZED ANXIETY DISORDER
- ☐ N92.0 - EXCESSIVE AND FREQUENT MENSTRUATION WITH REGULAR CYCLE
- ☐ F31.0 - BIPOLAR DISORDER, CURRENT EPISODE HYPOMANIC
- ☐ J44.9 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED
- ☐ F06.31 - MOOD DISORDER DUE TO KNOWN PHYSIOLOGY COND W DEPRESSV FEATURES
- ☐ K21.9 - GASTRO-ESOPHAGEAL REFLUX DISEASE WITHOUT ESOPHAGITIS
- ☐ E78.00 - PURE HYPERCHOLESTEROLEMIA, UNSPECIFIED
- ☐ F34.9 - PERSISTENT MOOD [AFFECTIVE] DISORDER, UNSPECIFIED
- ☐ F32.1 - MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, MODERATE
- ☐ F32.89 - OTHER SPECIFIED DEPRESSIVE EPISODES
- ☐ E55.9 - VITAMIN D DEFICIENCY, UNSPECIFIED
- ☐ F32.A - DEPRESSION, UNSPECIFIED

The diagnosis codes provided on this form do not represent an exclusive list of appropriate ICD-10 codes. Our company does not intend to imply that these codes should be used. The provider is responsible for determining the medical necessity of laboratory tests and for assigning and providing the specific ICD-10 code(s) to support the medical necessity of clinical laboratory test(s).

PHARMACOGENOMICS(PGx) FORM

TO BE FILLED IN BY PHYSICIAN

ORDERING PHYSICIAN/SENDING FACILITY (Each Listed person will receive a copy of the report)

*Facility Name (Facility Code):

*Client: | *Address: | *City:

*Phone: | *State/Country: | *Zip:

*Ordering Licensed Provider	*First Name	*Last Name	*Code	*NPI	*Fax/Phone

Additional Results Recipients

Genetic Counselor or Other Medical Provider	First Name	Last Name	Phone/Fax/Email

*ICD 10 CODES REQUIRED

PHARMACOGENOMICS(PGx) TEST PANEL

Pharmacogenomic panel covers 30 genetic markers

☐ **Cardiovascular panel**
This is an 9-gene panel customized to cardiovascular medications such as anti-coagulants, anti-platelet agents and statins. The genes covered are: VKORC1, CYP4F2, DBH, F2, F5, MTHFR, UGT2B15, SLCO1B1, SLC6A3/DAT1.

☐ **Oncology Pharmacogenomics panel**
This is a 4-gene panel customized for anti-cancer agents. The genes covered are: ABCB1, ABCG2, ADRA2A, TPMT.

☐ **Psychiatric panel**
This is a 14-gene panel customized for anti-psychotic and anti-depressant medications. Genes covered are: ANKK1, ApoE, BDNF, CACNA1C, COMT, CYP1A2, CYP2C19, CYP2C9, CYP2D6, CYP3A4, GRIK4, HTR2A, HTR2C, OPRK1.

☐ **Pain management and deaddiction panel**
This is an 3-gene panel customized for opioids and non-opioids. The genes covered are: CYP2B6, CYP3A5, OPRM1.

COMPREHENSIVE PHARMACOGENOMICS (PGx) TEST PANEL GENES ☐

ABCG2, ADRA2A, ANKK1, ApoE, BDNF, CACNA1C, COMT, CYP1A2, CYP2B6, CYP2C19, CYP2C9, CYP4F2, CYP2D6, CYP3A4, CYP3A5, DBH, F2, F5, MTHFR, GRIK4, HTR2A, HTR2C, OPRK1, OPRM1, SLCO1B1, TPMT, VKORC1, UGT2B15, ABCB1, SLC6A3/DAT1.

ORDERING PHYSICIAN CONSENT (SIGNATURE)

CONFIRMATION OF INFORMED CONSENT, PRE-TEST GENETIC COUNSELING, AND MEDICAL NECESSITY FOR GENETIC TESTING

The undersigned person (or representative thereof) ensures he/she is a licensed medical professional authorized to order genetic testing and confirms that the patient has given appropriate consent. I confirm that testing is medically necessary and the test results may impact medical management for the patient. I agree to allow......................... To facilitate the provision of pre-test genetic counseling services by a third party service, informed DNA (unless otherwise noted ☐), as required by the patient's insurance provider (unless this box is checked ☐) Furthermore, all information on this Requisition Form is true to the best of my knowledge. My signature applies to the attachment letter of medical necessity.

I attest that the patient has received and read the MicroGen Health Informed Consent document, or has had it read to him or her, and that I have fully informed the patient about the purpose, capabilities, and limitations of the ordered test. The patient has voluntarily given his or her full consent for the ordered test and a signed copy of this consent is available on file. Any MicroGen Health Informed Consent that the patient agrees to at a later date will supersede and replace this Informed Consent.

Statement of Medical Necessity

By signing below, I, the ordering Medical Provider, confirm that testing is medically necessary and that test results may impact medical management for the patient.

*Medical Professional Signature	*Name:	*Date: MM / DD / YYYY
*Ordering Physician Signature		*Date: MM / DD / YYYY

PHARMACOGENOMICS(PGx) FORM

INSTRUCTIONS:

1. Complete the patient and provider information section.
2. Read and sign the informed consent policy statement by the patient. Signature from the patient is required for billing and Test Authorization purposes.
3. Signature from the provider on Page 1 of the TRF is required for all testing.
4. Write in the test name on Page 1 or select the gene(s)/panel(s) below.
5. Indicate any relevant test options on Page 1.
6. Please visit www.microgenhealth.com for specimen requirements.

REQUIRED FOR INSURANCE CHECKLIST

1. Detailed medical record (pedigree if available)
2. ICD-10 code(s)
3. Physician, patient, and insured signatures
4. Medical Necessity Letter, Patient Informed Consent Document
5. Copy of insurance card(s) - front / back
6. Insurer specific forms (i.E. ABN)
7. Insurance authorization, if available
8. For medicare, medicare criteria form is required