PROMETHEUS® Anser® | PROMETHEUS® Monitr™ Crohn's Disease | PROMETHEUS® Risk Immune

Prometheus Laboratories

TEST REQUISITION

PLEASE PRINT

SAMPLE COLLECTION INFORMATION

DATE COLLECTED (required):

TIME COLLECTED:

PATIENT ID #:

SENDER SAMPLE ID #:

MEDICARE ONLY - HOSPITAL STATUS WHEN SAMPLE WAS COLLECTED:
☐ Hospital inpatient ☐ Hospital outpatient ☐ Non-hospital patient

LABORATORY/OTHER NAME/ADDRESS:

PHONE #: FAX #:

CONTACT:

RESULTS: ☐ Mail ☐ Fax ☐ No results to lab

PATIENT INFORMATION (REQUIRED)

LAST NAME:

FIRST NAME: MI:

ADDRESS: APT #:

CITY: STATE: ZIP:

HOME PHONE #:

OTHER PHONE #:

DOB: SEX: ☐ M ☐ F SSN:

ACKNOWLEDGMENT OF INFORMED CONSENT FOR GENETIC TESTING

My signature below indicates that I have read and understand the genetic consent requirement for my patient on the back page and acknowledge that I have obtained the appropriate consent from my patient.

PROVIDER SIGNATURE: _____ DATE: _____

BILLING INFORMATION (REQUIRED)

BILL: ☐ Provider account ☐ Insurance ☐ Laboratory ☐ Patient

☐ **MEDICARE - MEDICAL NECESSITY NOTICE:** When ordering tests for which Medicare reimbursement will be sought, physicians (or other individuals authorized by law to order tests) should only order tests that are medically necessary for the diagnosis or treatment of a patient, rather than for screening purposes.

I certify that the ordered test(s) is/are reasonable and medically necessary for the diagnosis, care, and treatment of this patient's condition.

ORDERING PROVIDER'S SIGNATURE: DATE:

PRINT NAME:

PRIMARY INSURANCE: As a courtesy, we will bill your insurance. Please attach a copy (front and back) of insurance card(s) and complete all information below. **NOTE: Parent or guardian information is required if patient is a minor. Parent or guardian is responsible for payment.**

NAME OF PARENT OR GUARDIAN (IF PATIENT IS UNDER 18 YEARS OF AGE):

INSURANCE CARRIER: POLICY #:

GROUP NAME: GROUP #:

ADDRESS:

CITY: STATE: ZIP:

PHONE #: FAX #:

POLICYHOLDER NAME:

POLICYHOLDER ID # (SSN):

POLICYHOLDER DOB: RELATION TO PATIENT:

POLICYHOLDER PHONE #:

SECONDARY INSURANCE: Attach a copy (front and back) of the secondary insurance card. Provide the insurance name, policy number and group name, billing address and phone, policyholder name, ID #, date of birth, relation to patient, and phone number.

PREAUTH/REFERENCE #: _____

PROVIDER/ACCOUNT INFORMATION

ACCOUNT NAME/ADDRESS:

PHONE #: FAX #:

PROVIDER/NPI #:

ICD CODE(S) (required):

Primary Code			
1	2	3	4

CLINICAL DIAGNOSIS: _____

ANSER REASON FOR ORDER (PLEASE SELECT ONE):

☐ Midinduction level ☐ Secondary loss of response ☐ Restart after drug holiday
☐ Postinduction level ☐ Infusion/allergic reaction ☐ Side effects
☐ Primary nonresponse ☐ Maintenance (asymptomatic)

MUST PROVIDE DOSAGE INFORMATION

Infusion/Injection Date: _____/_____/_____
Dose: _____ mg or _____ mg/kg
Frequency: Every _____ weeks

SELECT THE APPROPRIATE TEST TO BE PERFORMED

☐ **Anser IFX**—#3150
Measures **infliximab (IFX)** and antibodies-to-infliximab (ATI) levels in serum. Validated for use in patients treated with these medications.

Select medication: ☐ **REMICADE® (infliximab)** ☐ **INFLECTRA® (infliximab-dyyb)** ☐ **RENFLEXIS® (infliximab-abda)**

☐ **Anser ADA**—#3170
Measures **adalimumab (ADA)** and antibodies-to-adalimumab (ATA) levels in serum.

☐ **Anser VDZ**—#3180
Measures **vedolizumab (VDZ)** and antibodies-to-vedolizumab (ATV) levels in serum.

☐ **Anser UST**—#3190
Measures **ustekinumab (UST)** and antibodies-to-ustekinumab (ATU) levels in serum.

☐ **Monitr Crohn's Disease**—#7300
13 biomarkers to assess endoscopic disease activity in adult Crohn's disease patients.

☐ **RiskImmune**—#3600† **New**
Aids in predicting risk of antibody formation to infliximab, adalimumab or biosimilars

(By selecting an ADD option below, you are ordering a conditional add-on test following a RiskImmune result consistent with an increased risk of antibody formation to infliximab or adalimumab.)

☐ ADD **TPMT Genetics** - #3300†
☐ ADD **TPMT Enzyme** - #3320

☐ **TPMT Genetics**—#3300†

☐ **TPMT Enzyme**—#3320

☐ **Thiopurine Metabolites**—#3200†

Current therapeutic:
☐ 6-MP_____mg/day ☐ AZA_____mg/day ☐ Other _____mg/day

If billing differs from Anser for other test(s) ordered, please list test name(s) below and select which entity should be billed separately.

Test Name(s)_____

Bill to:
☐ Provider Account ☐ Patient ☐ Medicare ☐ Insurance ☐ Laboratory

† **Acknowledgment of informed consent for NY state. Specimen collection requirements on back.**

SPECIMEN COLLECTION AND HANDLING PROCEDURES

Test Ordered (Turnaround Time From Date of Receipt)[a]	Transportation Kit Requirements	Type of Specimen Required	Tube for Specimen Collection	Recommended Specimen Volume	Storage Conditions	Stability of Specimen
Anser (ADA, IFX, UST, VDZ) (3 days)	Ambient or cold pack acceptable	SERUM	Serum Separator Tube or Red-Top Tube	2.0 mL (0.5 mL for Peds)	Room temperature or refrigerate Do not freeze	Room temp: 7 days Refrigerated: 9 days
Monitr Crohn's Disease (3 days)	Refrigeration preferred, ship with cold pack	SERUM	**SPUN** Serum Separator Tube	2.0 mL Serum	Room temperature or refrigerate Do not freeze	Room temp: 3 days Refrigerated: 14 days
RiskImmune (4 days)	Ambient or cold pack acceptable	WHOLE BLOOD	EDTA/Lavender-Top Tube	2.0 mL Whole Blood	Room temperature or refrigerate Do not freeze	Room temp: 10 days Refrigerated: 30 days
TPMT Genetics (4 days)	Ambient or cold pack acceptable	WHOLE BLOOD	EDTA/Lavender-Top Tube	2.0 mL Whole Blood	Room temperature or refrigerate Do not freeze	Room temp: 10 days Refrigerated: 30 days
TPMT Enzyme (3 days)	Refrigerated preferred, ship with cold pack	WHOLE BLOOD	EDTA/Lavender-Top Tube	5.0 mL Whole Blood	Room temperature or refrigerate Do not freeze	Room temp: 24 hours Refrigerated: 8 days
Thiopurine Metabolites (3 days)	Refrigerated preferred, ship with cold pack	WHOLE BLOOD	EDTA/Lavender-Top Tube	5.0 mL Whole Blood	Room temperature or refrigerate Do not freeze	Room temp: 3 days Refrigerated: 8 days

[a]Business Days

Specimens should be labeled with 2 identifiers and date of collection. Examples of acceptable identifiers include, but are not limited to, patient name, date of birth, hospital number, and requisition, accession, or unique random number. Unlabeled specimens will not be accepted for testing.

SHIPPING INSTRUCTIONS: Prometheus has an agreement with FedEx® Express for priority overnight delivery service within the United States and Canada. Please call FedEx to schedule a pickup at 1-800-GoFedEx (463-3339). FedEx will pick up your specimens and ship them to Prometheus Laboratories Inc in San Diego at no expense to you. Prometheus will provide specimen transportation kits upon request.
NOTE: Multiple specimens may be shipped in a single transportation kit. **For more information, call Client Services at 888-423-5227, or go to www.prometheuslabs.com.**

ACKNOWLEDGEMENT OF INFORMED CONSENT FOR NEW YORK STATE ONLY
I warrant that this test was ordered and that I have obtained the appropriate prior written consent. This written consent was signed by the person who is the subject of the test (or if that person lacks capacity to consent, signed by the person authorized to consent for that person) and includes the following (unless certain that the following information is not required by the state in which I practice):

1. The purpose of this test is to determine if the patient may have a variant in the gene(s) being tested, which has been found to be associated with this condition.
2. This test will only test for this specific condition and will not detect ALL possible variants within this gene, nor will it detect variants in other genes.
3. Prior to my signature of the written consent, a qualified healthcare professional discussed with the patient the genetic test ordered and described the steps involved in the test, the constraints of the procedure, and its accuracy.
4. My patient was advised by a qualified healthcare professional of the risks and benefits of genetic testing, and advised of the significance of a positive and negative result.
5. The patient understands that a positive test result is an indication that the patient may be predisposed to, or have, the condition listed above.
6. The patient understands that the test may fail, that the results may be non-informative or not predictive for his/her case, and that the test may reveal information that is unrelated to their intended purpose.
7. No unauthorized test is performed on specimens.
8. Specimens will be destroyed within 60 days after collection when no longer required for clinical purposes.
9. The informed consent does not authorize the use or release of any other identified medical information unrelated to this genetic test.
10. The patient understood that he/she could see professional genetic counseling prior to undergoing the testing procedure, and received written information identifying a genetic counselor or medical geneticist by his/her treating provider.

Prometheus tests are laboratory-developed tests that were developed and validated under Federal CLIA laboratory guidelines by Prometheus.
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