Ayass bioscience
Bridging Science and Precision Patient Care LLC™

PHARMACOGENETIC Testing Requisition

1. PATIENT INFORMATION

Last Name | First Name | MI

Address

City | State | Zip

Phone | DOB (mm/dd/yyyy) | Gender ☐ Male ☐ Female

Ancestry
☐ Caucasian ☐ Eastern European ☐ Northern European
☐ Western European ☐ Native American ☐ Middle Eastern
☐ African American ☐ Asian ☐ Pacific Islander
☐ Caribbean ☐ Central/South American ☐ Other: _____
☐ Ashkenazi Jewish ☐ Hispanic

Email

PLEASE PROVIDE LIST OF CURRENT MEDICATIONS

2. PROVIDER INFORMATION

Clinic Name

Physician Name | NPI#

Address | City

State | Zip | Phone

Fax | Email

3. SPECIMEN COLLECTION

Specimen Type ☐ Whole Blood ☐ Saliva | Date of Collection (mm/dd/yyyy) | Time of Collection (HH:MM) ☐ AM ☐ PM

Patient has had a blood transfusion ☐ Yes ☐ No | If "Yes" - Date of the last transfusion (mm/dd/yyyy)

2-4 weeks of wait time is required for some testing.
Specimens are not accepted for patients who have had allogeneic bone marrow transplants.

4. BILLING INFORMATION

BILL: ☐ Insurance ☐ Medicaid ☐ Medicare ☐ Self Pay ☐ Worker's Compensation ☐ Uninsured

Insurance Company

Name of Policyholder | DOB (mm/dd/yyyy) | Subsriber ID | Group#

Relationship to Policyholder
☐ Self ☐ Spouse ☐ Dependant ☐ Other_____

Worker's Comp. Claim# | Date of Injury (mm/dd/yyyy)

5. PHARMACOGENETIC TESTING PANELS

ICD-10 DIAGNOSIS CODES: _____ _____ _____ _____ _____ _____ _____ _____ _____

☐ **MEDICAL MANAGEMENT**
ABCB1, ANKK1/DRD2, APOE, COMT, CYP1A2, CYP2B6, CYP2C19, CYP2CP, CYP2D6, CYP3A4, CYP3A5, F2, F5, MTHFR, OPRM1, SLCO1B1, VKORC1

☐ **PAIN MANAGEMENT**
COMT, CYP1A2, CYP2C19, CYP2C9, CYP2D6, OPRM1

☐ **MENTAL HEALTH**
ANKK1/DRD2, APOE, COMT, CYP1A2, CYP2B6, CYP2C19, CYP2C9, CYP2D6, MTHFR, OPRM1

☐ **ORTHOPEDIC**
CYP2C9, CYP2D6, F2, F5, MTHFR, VKORC1

☐ **CARDIOVASCULAR**
APOE, CYP2C19, CYP2C9, CYP2D6, CYP3A4, F2, F5, MTHFR, SLCO1B1, VKORC1

☐ **CLOPIDOGREL**
CYP2C19, CYP3A5

☐ **THROMBOSIS**
F2, F5, MTHFR

☐ **WARFARIN (COUMADIN)**
CYP2C9, VKORC1

Tests can be ordered as a panels or individually

6. PATIENT CONSENT

Billing ABN and Patient Plan Information: A completed Advance Beneficiary Notice (ABN) of coverage is required for Medicare patients who do not meet medical criteria for testing. This does not apply to specific site analyses. Insurance pre-qualification will not be performed for these tests, unless specifically requested. All tests ordered shall be processed and billed based on payor.

Patient Acknowledgment: I am covered by insurance and authorize Ayass BioScience, LLC to give my designated insurance plan on this form and other information provided by my health care provider necessary for reimbursement. I authorize Ayass BioScience, LLC to inform my Plan of my test results only if test results are required for preauthorization of or payment for reflex/additional testing. I authorize Plan benefits to be payable to Ayass BioScience, LLC. I further authorize payment of benefits directly to the laboratory. I understand 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 understand that any payment I receive for services rendered by the laboratory from my insurance provider should be forwarded immediately to the laboratory.

The data may also reveal secondary or incidental findings such as, that you may be at risk for certain genetic diseases or you are a carrier of disease associated mutations.

Patient Consent: My signature below constitutes my acknowledgment that the benefits, risks, and limitations of this testing have been explained to my satisfaction by a qualified health professional and I have received a copy of the full informed consent document. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask questions at any other time. I voluntarily agree to genetic testing.

Patient Consent for Research: ☐ By checking this box I DO NOT consent for the remaining part of my sample to be used for research purposes by Ayass BioScience, LLC.
Personal information will not be shared and will be kept confidential by Ayass BioScience, LLC.

If Signature is other than patient's. Printed Name _____

(mm/dd/yyyy)

PATIENT'S OR RESPONSIBLE PARTY'S SIGNATURE | DATE

7. MEDICAL NECESSITY FOR TESTING

This test is medically necessary for the diagnosis or detection of a disease, illness, impairment, syndrome or disorder, and these results will be used in the medical management and treatment for this patient. Furthermore, additional results recipients' information is true and correct to the best of my knowledge. The person listed as the Ordering Physician or genetic counselor is authorized by law to order the test(s) requested herein. I confirm that I have provided pharmacogenetic testing information to the patient and they have consented to genetic testing. Please check all that apply:

☐ I confirm that the above patient's gene testing is medically necessary and the result will be used in the medical management and dosing or consideration of medications for this individual patient's therapy.
☐ I agree to allow Ayass BioScience, LLC to transfer the information contained in this requisition to an Letter of Medical Necessity (LMN) using the ordering physician's name as his/her signature for insurance billing purposes.
☐ I have attached a LMN for insurance billing purposes.
☐ Patient meets clinical/genetic testing criteria for the above ordered tests.

(mm/dd/yyyy)

HEALTH CARE PROVIDER'S SIGNATURE | DATE

TEST SUBMISSION CHECKLIST

☐ Copy of Patient Demographics
☐ Current Meds List
☐ ICD-10 Diagnosis Codes
☐ Patient's/Provider's Signatures
☐ Copy of Insurance Card (Front/Back)
☐ Attach Patient's Insurance Pre-Authorization Form

Collected by: _____
Signature

PGX-RF-V8

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Ayass BioScience, LLC DBA Ayass Laboratory, LLC