

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):

CLINICAL DIAGNOSIS: _____

PROMETHEUS TESTING ONLY. NO SUBSTITUTIONS.*

SELECT THE APPROPRIATE TEST TO BE PERFORMED

CHECK BOX ON LEFT NEXT TO TEST BEING ORDERED.
SPECIMEN COLLECTION REQUIREMENTS ON BACK.

IBD sgi Diagnostic* - #1800+
(By selecting an ADD option below, you are ordering a conditional add-on test order.)
 ADD Monitr™ Crohn's Disease - #7300
(Conditional order following an IBD sgi result consistent with Crohn's disease.)
 ADD RiskImmune™ - #3600+
(Conditional order following an IBD sgi result consistent with Inflammatory Bowel Disease.)

Monitr Crohn's Disease - #7300
13 biomarkers to assess endoscopic disease activity in 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

Crohn's Prognostic-#2001+

7C4 Diagnostic Test - #8205

IBD

TPMT Genetics - #3300+

TPMT Enzyme - #3320

Thiopurine Metabolites - #3200

Current therapeutic:
 6-MP _____ mg/day AZA _____ mg/day Other _____ mg/day

THIOPURINE MGMT

Celiac PLUS - #6360+

Celiac Genetics - #6260+ (genetics only)

Celiac Serology - #1155 (serology only)

Includes the following:
 Tissue transglutaminase (tTG) IgA recombinant antigen - #1405
 Anti-endomysial (EMA) IgA - #1505 Total serum IgA - #1605
 DGP IgA - #1255 DGP IgG - #1355

CELIAC

FIBROSpect® HCV - #4000
Assessment of liver fibrosis severity for HCV patients.

FIBROSpect® NASH - #4100
Assessment of liver fibrosis severity for NASH patients.

LIVER

LactoTYPE® - #6100+

Other Prometheus test(s): _____

ADD'L TESTS

*By using this Prometheus test requisition, you are specifically requesting that your patient's specimen be sent to Prometheus for testing and asking that no alternative test be performed.

+ Acknowledgment of informed consent for NY state.

9410 Carroll Park Drive, San Diego, CA 92121 • www.prometheuslabs.com
Toll-free: 888-423-5227 • Phone: 858-824-0895 • Fax: 877-816-4019

DX.1002v4 (01/2021)

SPECIMEN COLLECTION AND HANDLING PROCEDURES

Test Ordered (Turnaround Time From Date of Receipt) ^a	Specimen Requirements	Recommended Specimen Volume ^b	Specimen Storage/Stability ^c	Transportation Kit Requirements
IBD sgi Diagnostic (4 days)	SERUM AND WHOLE BLOOD in Serum Separator or Red-Top Tube AND EDTA/Lavender-Top Tube	2.0 mL serum AND 2.0 mL whole blood	Room temp: 7 days Refrigerated: 21 days	Ambient or cold pack acceptable
Monitr Crohn's Disease (3 days)	SERUM in SPUN Serum Separator Tube	2.0 mL serum	Room temp: 3 days Refrigerated: 14 days	Refrigerated preferred, ship with cold pack
RiskImmune (4 days)	WHOLE BLOOD in EDTA/Lavender-Top Tube	2.0 mL whole blood	Room temp: 10 days Refrigerated: 30 days	Ambient or cold pack acceptable
Crohn's Prognostic (7 days)	SERUM AND WHOLE BLOOD in Serum Separator or Red-Top Tube AND EDTA/Lavender-Top Tube	2.0 mL serum AND 2.0 mL whole blood	Room temp: 7 days Refrigerated: 7 days	Ambient or cold pack acceptable
7C4 Diagnostic Test (7 days)	SERUM in Serum Separator or Red-Top Tube	1.0 mL serum	Room temp: 3 days Refrigerated: 7 days	Cold pack required
Celiac PLUS (PROMETHEUS Celiac Genetics and PROMETHEUS Celiac Serology) (4 days)	SERUM AND WHOLE BLOOD in Serum Separator or Red-Top Tube AND EDTA/Lavender-Top Tube	2.0 mL serum AND 2.0 mL whole blood	Room temp: 7 days Refrigerated: 30 days	Ambient or cold pack acceptable
Celiac Genetics (4 days)	WHOLE BLOOD in EDTA/Lavender-Top Tube	2.0 mL whole blood	Room temp: 7 days Refrigerated: 30 days	Ambient or cold pack acceptable
Celiac Serology (4 days)	SERUM in Serum Separator or Red-Top Tube	2.0 mL serum (0.5 mL for peds)	Room temp: 7 days Refrigerated: 30 days	Ambient or cold pack acceptable
TPMT Genetics (4 days)	WHOLE BLOOD in EDTA/Lavender-Top Tube	2.0 mL whole blood	Room temp: 10 days Refrigerated: 30 days	Ambient or cold pack acceptable
TPMT Enzyme (3 days)	WHOLE BLOOD in EDTA/Lavender-Top Tube	5.0 mL whole blood	Room temp: 24 hours Refrigerated: 8 days	Refrigerated preferred, ship with cold pack
Thiopurine Metabolites (3 days)	WHOLE BLOOD in EDTA/Lavender-Top Tube	5.0 mL whole blood	Room temp: 3 days Refrigerated: 8 days	Refrigerated preferred, ship with cold pack
FIBROSpect HCV FIBROSpect NASH (7 days)	SERUM in Serum Separator or Red-Top Tube	2.0 mL serum (0.5 mL for peds)	Room temp: 7 days Refrigerated: 30 days	Ambient or cold pack acceptable
LactoTYPE (7 days)	WHOLE BLOOD in EDTA/Lavender-Top Tube	2.0 mL whole blood	Room temp: 10 days Refrigerated: 30 days	Ambient or cold pack acceptable

^aBusiness days. | ^bNote: Minimum specimen volume for genetic testing may vary with the white blood cell count. | ^cFrozen stability data may be available. Contact Client Services if detailed information is needed.

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, 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):

- 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.
- 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.
- 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.
- 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.
- The patient understands that a positive test result is an indication that the patient may be predisposed to, or have, the condition listed above.
- 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.
- No unauthorized test is performed on specimens.
- Specimens will be destroyed within 60 days after collection when no longer required for clinical purposes.
- The informed consent does not authorize the use or release of any other identified medical information unrelated to this genetic test.
- 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.

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

PROMETHEUS, Anser, FIBROSpect, IBD sgi Diagnostic, LactoTYPE, Monitr and RiskImmune are trademarks or registered trademarks of Prometheus Laboratories Inc, San Diego, California. All other trademarks or service marks are the property of their respective owners.

©2021 Prometheus Laboratories Inc. All rights reserved.