Prometheus Laboratories | GENERAL GI REQUISITION

All information requested is REQUIRED to process testing and/or submit insurance claims on your patient's behalf.
Prometheus Client Services | 888-423-5227 | 6:00 am - 4:30 pm Pacific Time

Patient Information

Last Name:_____

First Name:_____ MI:_____ Sex: ☐M ☐F

DOB (mm/dd/yyyy):_____ SSN: _____

Parent/Guardian (if applicable):_____
(REQUIRED if patient is <18 years old at time of sample collection)

Address:_____ City:_____

State:_____Zip:_____Phone:_____

ICD-10 Diagnosis Code(s)

Primary ICD-10 Code (REQUIRED)		Additional ICD-10 Code(s) (OPTIONAL)					
1		2		3		4	

Billing Information

BILL: ☐Insurance* ☐Laboratory ☐Patient/Self-Pay ☐Provider Account
*Please provide details below AND attach a front/back copy of insurance card(s).

Insurance Carrier: _____ Policy #:_____

Provider/Account Information

Account Name/Address:

Phone: Fax:

Ordering Provider Selection & Signature (REQUIRED)

Clearly select the ordering provider from list below (circle or ✓).
If provider is not listed, please provide their FULL NAME AND NPI:

[ ] [ ]
[ ] [ ]
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Provider: _____ **NPI:**_____

I certify the ordered test(s) is/are reasonable and medically necessary for the diagnosis, care, and/or treatment of this patient's condition as documented in the medical record.
If this patient is <18 years old at the time of testing, the parent/guardian has been informed that they will be responsible for any costs associated with testing.
†**Informed consent for genetic testing:** I have read and understand the genetic consent requirement on page two and acknowledge I have obtained consent from my patient.

Signature:_____

Name:_____ Date:_____

Sample Collection Information

Date (mm/dd/yyyy): _____ Time: _____ ☐AM ☐PM

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:

Results: ☐Mail ☐Fax ☐No Results to Lab

Select Test(s) To Be Performed

— Therapeutic Drug Monitoring —

☐ **Anser® IFX** (#3150)
Simultaneously measures serum infliximab (IFX) & antibodies-to-IFX (ATI).
Select biologic (optional):
☐**REMICADE®** (infliximab) ☐**INFLECTRA®** (IFX-dyyb) ☐**RENFLEXIS®** (IFX-abda)
☐**AVSOLA®** (IFX-axxq) ☐**Other IFX:** _____

☐ **Anser® ADA** (#3170)
Simultaneously measures serum adalimumab (ADA) & antibodies-to-ADA (ATA).
Select biologic (optional):
☐**HUMIRA®** (adalimumab) ☐**Other ADA:** _____

☐ **Anser® VDZ** (#3180)
Simultaneously measures serum vedolizumab (VDZ) & antibodies-to-VDZ (ATV).

☐ **Anser® UST** (#3190)
Simultaneously measures serum ustekinumab (UST) & antibodies-to-UST (ATU).
Select biologic (optional):
☐**STELARA®** (ustekinumab) ☐**Other UST:** _____

☐ **Anser® RZB** (#3140) New
Simultaneously measures serum risankizumab (RZB) & antibodies-to-RZB (ATR).

Anser Testing - Biologic Dosing Data (optional)

Date of Last Dose (mm/dd/yyyy)	Current Dose	Current Interval
	☐mg ☐mg/kg	☐days ☐weeks

☐ **RiskImmune®†** (#3600)
Assesses genetic predisposition to immunogenicity to anti-TNF therapy.

☐ **TPMT Genetics†** (#3300)
Aids in individualized thiopurine dosing based on patient TPMT genotype.

☐ **TPMT Enzyme** (#3320)
Phenotyping test that aids in individualized thiopurine dosing.

☐ **Thiopurine Metabolites** (#3200)
Aids in optimization of thiopurine dosing to achieve clinical response.

Current Thiopurine Dosing (optional)

☐ 6-MP _____ mg/day	☐ AZA _____ mg/day	☐ Other _____ mg/day

— Celiac, Bile Acid Malabsorption, Liver & Lactase Non-Persistence —

☐ **Celiac PLUS†** (#6360)
Includes Celiac Genetics and Celiac Serology.
☐ ONLY **Celiac Genetics†** (#6260)
Genetic profile to aid diagnosis of celiac disease.
☐ ONLY **Celiac Serology** (#1155)
Antibody profile to aid diagnosis of celiac disease.
— ONLY the following designated component(s) of Celiac Serology —
☐ Anti-Human Tissue Transglutaminase IgA (tTG IgA) (#1405)
☐ Anti-Endomysial IgA (EMA IgA) (#1505) ☐ Total serum IgA (#1605)
☐ DGP IgA (#1255) ☐ DGP IgG (#1355)

☐ **7C4 Diagnostic** (#8205)
Measures 7α-hydroxy-4-cholesten-3-one (7C4) to determine if bile acid malabsorption may be the underlying cause of GI symptoms.

☐ **FIBRO*Spect*® HCV** (#4000)
Assessment of liver fibrosis severity for HCV patients.

☐ **FIBRO*Spect*® NASH** (#4100)
Assessment of liver fibrosis severity for NASH patients.

☐ **Lacto*TYPE*®†** (#6100)
Genetic test that aids in identification of primary lactase non-persistence.

Miscellaneous Testing

☐ **Other Prometheus Testing†:**_____
†Acknowledgment of informed consent required if genetic testing is indicated above. Refer to page two or contact Client Services to confirm specimen requirements.

IBD: Inflammatory bowel disease; UC: Ulcerative colitis; CD: Crohn's disease; TPMT: thiopurine methyltransferase; HCV: Hepatitis C; NASH: Non-alcoholic steatohepatitis

— Specimen collection requirements on page 2 —

†Acknowledgment of informed consent for genetic testing required.
***Failure to provide the required data, at the time of sample collection, may result in reporting delay/cancellation.**

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Specimen Collection and Handling Procedures					
Test Ordered	**Turnaround Time[a]**	**Transport Kit and Storage Conditions**	**Specimen Type and Volume**	**Specimen Collection Tube**	**Specimen Stability**
7C4 Diagnostic	7 days	**Cold pack REQUIRED** **Do not freeze**	1.0 mL Serum	Serum Separator Tube or Red-Top Tube	Room temp: 3 days Refrigerated: 7 days
Anser ADA, IFX, RZB, UST, VDZ	3 days	Ambient or cold pack **Do not freeze**	2.0 mL Serum (0.5 mL for Peds)	Serum Separator Tube or Red-Top Tube	Room temp: 14 days Refrigerated: 14 days
Celiac PLUS†	4 days	Ambient or cold pack **Do not freeze**	2.0 mL Serum **AND** 2.0 mL Whole Blood	Serum Separator Tube or Red-Top Tube **AND** EDTA/Lavender-Top Tube	Room temp: 7 days Refrigerated: 30 days
Celiac Genetics†	4 days	Ambient or cold pack **Do not freeze**	2.0 mL Whole Blood	EDTA/Lavender-Top Tube	Room temp: 7 days Refrigerated: 30 days
Celiac Serology (including all components)	4 days	Ambient or cold pack **Do not freeze**	2.0 mL Serum (0.5 mL for peds)	Serum Separator Tube or Red-Top Tube	Room temp: 7 days Refrigerated: 30 days
Crohn's Prognostic†	7 days	Ambient or cold pack **Do not freeze**	2.0 mL Serum **AND** 2.0 mL Whole Blood	Serum Separator Tube or Red-Top Tube **AND** EDTA/Lavender-Top Tube	Room temp: 7 days Refrigerated: 7 days
FIBRO*Spect* HCV, NASH	7 days	Ambient or cold pack **Do not freeze**	2.0 mL Serum (0.5 mL for peds)	Serum Separator Tube or Red-Top Tube	Room temp: 7 days Refrigerated: 30 days
IBD sgi Diagnostic*†	4 days	Ambient or cold pack **Do not freeze**	2.0 mL Serum **AND** 2.0 mL Whole Blood	Serum Separator Tube or Red-Top Tube **AND** EDTA/Lavender-Top Tube	Room temp: 7 days Refrigerated: 21 days
Lacto*TYPE*†	7 days	Ambient or cold pack **Do not freeze**	2.0 mL Whole Blood	EDTA/Lavender-Top Tube	Room temp: 7 days Refrigerated: 30 days
Monitr® Crohn's Disease	5-7 days	Cold pack preferred **Do not freeze**	2.0 mL **SPUN** Serum	**SPUN** Serum Separator Tube	Room temp: 3 days Refrigerated: 14 days
RiskImmune*†	4 days	Ambient or cold pack. **Do not freeze**	2.0 mL Whole Blood	EDTA/Lavender-Top Tube	Room temp: 10 days Refrigerated: 30 days
Thiopurine Metabolites	3 days	Cold pack preferred **Do not freeze**	5.0 mL Whole Blood	EDTA/Lavender-Top Tube	Room temp: 24 hours Refrigerated: 8 days
TPMT Enzyme	3 days	Cold pack preferred **Do not freeze**	5.0 mL Whole Blood	EDTA/Lavender-Top Tube	Room temp: 24 hours Refrigerated: 8 days
TPMT Genetics†	4 days	Ambient or cold pack **Do not freeze**	2.0 mL Whole Blood	EDTA/Lavender-Top Tube	Room temp: 10 days Refrigerated: 30 days

[a]Business days from date of receipt.
†Acknowledgment of informed consent for genetic testing required.
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® for express overnight delivery within the United States and Canada. Please call FedEx at 1-800-GoFedEx (463-3339) to schedule a pickup. 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 prometheuslabs.com.**

ACKNOWLEDGMENT OF INFORMED CONSENT FOR GENETIC TESTING

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.
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. NY-state 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.