ClarityLabs
Testing for Better Health

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CLIA # 31D2140149

PGX REQUISITION

1 ACCOUNT INFORMATION

2 PATIENT INFORMATION

Last Name First Name

D.O.B (MM/DD/YY) Sex ☐ M ☐ F

Phone (Day) (Evening)

Insured's Address Apt.

City State Zip

I authorize Clarity Labs to release the results of this testing to the treating physician or facility. I have read and understood the ABN printed on the backside of this form.

X

Patient Signature Date

3 INSURANCE INFORMATION ☐ Client Bill ☐ See Attached Insurance Forms

Insured's Name (if different from Patient)

Primary Insurance Name & Plan / Workers Comp. Carrier

Address (Insurance)

Policy ID # Group/Plan/Book #

☐ Cash ☐ Check Received by: _____

☐ Bill Patient ☐ Bill Client ☐ Bill Insurance

SPECIMEN INFORMATION

Date Collected: ____ /____ /____ Time: ____ : ____ AM PM Collector: _____

Specimen Type: ☐ Blood ☐ Buccal Swab ☐ Other: _____

FOR LAB USE ONLY

Date: _____ /_____ /_____

Received by: _____ Time: _____ : _____ AM PM

4 TEST MENU - Check Boxes

5088 ❑ CARDIAC Panel	CYP2C19 CYP2D6 CYP2C9 CYP3A4 CYP3A5 SLCO1B1 APOE VKORC1 LPA ITGB3
5089 ❑ PSYCH Panel	CYP2C19 CYP2D6 CYP2C9 CYP3A4 CYP3A5 CYP1A2 ANKK1/DRD2 COMT HTR2A HTR2C UGT2B15
5087 ❑ PAIN Panel	CYP2C19 CYP2D6 CYP2C9 CYP3A4 CYP3A5 CYP1A2 CYP2B6 OPRM1
5086 ❑ COMPREHENSIVE Panel	CYP2C19 CYP2D6 CYP2C9 CYP3A4 CYP3A5 CYP1A2 CYP2B6 SLCO1B1 APOE VKORC1 ANKK1/DRD2 OPRM1 COMT HTR2A HTR2B LPA ITGB3 UGT2B15
5090 ❑ CYP2C9/VKORC1	CYP2C9 VKORC1
5092 ❑ CYP2D6	CYP2D6
5091 ❑ CYP2C19	CYP2C19

CUSTOM PROFILES/ADDITIONAL GENES

Y435 ☐ CYP2C9	Y445 ☐ CYP3A5	Y455 ☐ CYP2B6	Y469 ☐ APOE	Y461 ☐ OPRM1	Y493 ☐ HTR2A	Y499 ☐ LPA	Y503 ☐ UGT2B15
Y433 ☐ CYP3A4	Y453 ☐ CYP1A2	Y463 ☐ SLCO1B1	Y467 ☐ ANKK1	Y475 ☐ COMT	Y495 ☐ HTR2C	Y501 ☐ ITGB3	Y465 ☐ VKORC1

INDICATION FOR TESTING/ICD-10 - Common Indications Provided as a Convenience Indication(s) Required. Check all that apply. Add other applicable ICD-10 codes and descriptions in the spaces provided.

PAIN

☐	G89.4	Chronic Pain Syndrome
☐	G89.29	Other Chronic Pain
☐	G89.11	Acute Pain Due To Trauma
☐	R52	Other Acute Pain
☐	M54.08	Other Symptoms Referable To Back
☐	R52	Generalized Pain
☐	M54.5	Lumbago
☐	M54.2	Cervicalgia
☐	M54.6	Pain In Thoracic Spine
☐	M25.50	Pain In Joint Site Unspecified

CARDIAC

☐	I10	Unspecified Essential Hypertension
☐	I10	Benign Essential Hypertension
☐	I20.8 - I20.9	Other And Unspecified Angina Pectoris
☐	I42.7	Secondary Cardiomyopathy Unspecified
☐	I48.91	Atrial Fibrillation
☐	I25.10	Coronary Atherosclerosis of Unspecified Type of Vessel Native or Graft
☐	I70.0	Atherosclerosis of Aorta
☐	I73.9	Peripheral Vascular Disease Unspecified
☐	I50.9	Congestive Heart Failure Unspecified
☐	I21.3	Acute Myocardial Infarction of Unspecified Site Episode of Care Unspecified
☐	I65.29	Occlusion And Stenosis of Carotid Artery Without Cerebral Infarction

Add OTHER _____

PSYCHIATRIC

☐	F41.1	Generalized Anxiety Disorder
☐	F43.10 - F43.12	Posttraumatic Stress Disorder
☐	F34.1	Dysthymic Disorder
☐	E32.9	Depressive Disorder Not Elsewhere Classified
☐	F33.9	Major Depressive Affective Disorder Recurrent Episode
☐	T50.905A	Unspecified Degree

GENERAL

☐	T50.905A	Unspecified Adverse Effect of Unspecified Drug, Medicinal and Biological Substance
☐	E66.01	Morbid Obesity
☐	Z79.899	Long-Term (Current) Use of Other Medications
☐	E11.9	Diabetes Mellitus Without Mention of Complication, Type II or Unspecified Type, Uncontrolled
☐	I67.1	Cerebral Aneurysm Nonruptured
☐	M19.90	Osteoarthrosis Unspecified Whether Generalized or Localized Involving Unspecified Site
☐	B20	Human Immunodeficiency Virus [HIV] Disease
☐	C17-C17.9	Malignant Neoplasm of Colon
☐	C22-C22.9	Malignant Neoplasm of Liver and Intrahepatic Bile Ducts
☐	C34-C34.92	Malignant Neoplasm of Bronchus and Lung
☐	Z21	Asymptomatic Human Immunodeficiency Virus [HIV] Infection Status
☐	Z79.01	Long Term (Current) Use of Anticoagulants
☐	Z79-Z79.890	Long Term Current Drug Therapy
☐	Z79.891	Long Term (Current) Use of Opiate Analgesic
☐	Z79.899	Other Long Term (Current) Drug Therapy

5 PATIENT AUTHORIZATION

I authorize the collection of this specimen for the purpose of analytical testing by Clarity Labs and release of results to my treating physician and staff. I authorize Clarity Labs and or its designees to obtain insurance and billing information and release of such information as necessary to determine and collect benefits. I understand I am financially responsible for payments should Insurance be denied, partially paid, or co-payments required.

Patient Siganture: _____ **INTIALS** _____ **MONTH** ___ **DAY** ___ **YEAR** _____

ADDITIONAL INFORMATION REQUIRED ON THE BACK OF THIS PAGE

LETTER OF MEDICAL NECESSITY FOR PHARMACOGENETICS TESTING

PHYSICIAN INFORMATION

☐ See Attached Face Sheet

Last Name _____ M. Name _____ First Name_____

Title _____NPI _____ Phone (_____) _____

Address _____City _____State_____ Zip Code _____

PATIENT INFORMATION

☐ See Attached Face Sheet

Last Name _____M. Name _____ First Name _____

☐Male ☐Female DOB _____/_____/_____ Phone (_____) _____

Address _____City _____State _____Zip Code_____

Dear Insurance Representative:

My Patient _____has several medical conditions requiring prescriptions drugs. Given the conditions and drug being used, testing for drug metabolism and/or certain genetic risk factors is medically necessary. These indications are clearly documented in the paperwork and supporting documentation provided to the laboratory at the time of the test requisition.
I ordered the test for this patient in order to understand possible dangers and risks for suboptimal outcomes for specific medications currently prescribed or under considerations.

SPECIFICALLY TO ASSESS: _____ (Mandatory Information)

☐ High potential for experiencing adverse drug reaction and episodic events
☐ High potential for experiencing thromboembolism, hyperhomocysteinmia and hyperlipidemia
☐ Efficacy of current and/or future drug therapy
☐ Drug therapy best matched to patient's metabolic genotype/phenotype
☐ Correct dosage(s) to maximize therapeutic effect
☐ Other: _____

PATIENT'S HISTORY/MEDICATIONS TAKEN AND FOR WHAT REASON: (Mandatory Information)

_____
_____
_____

TREATMENT PLAN STATEMENT: _____

I plan to use the information to improve treatment care through the following:

☐ Identify current medications that may be causing adverse reactions, such as _____
☐ Identify and prescribe new medications that will provide maximum therapeutic effect without also causing harmful adverse reactions.
☐ Determine the optimal dosage(s) for current or potential future medications to ensure maximum effect.
☐ Other: _____

CONFIRMATION OF MEDICAL NECESSITY/INFORMED CONSENT

I am requesting that Clarity Labs, LLC perform a test(s) for the indications provided on this requisition form. I confirm that the patient has been supplied information regarding genetic testing and the patient has given consent for genetic testing to be performed. I confirm that this test is medically necessary for the diagnosis or detection of a disease, illness, impairment, syndrome or disorder, and that these results will be used in the medical management and treatment decisions for this patient.

Physician Signature: _____ Date: _____