EIV DIAGNOSTICS

By: EIV Diagnostics
CLIA# 05D2181132

Date of Collection: MM / DD / YY (Required) Time: : AM / PM (Required)

CLINIC INFORMATION

Clinic Name

Address | City, State, Zip

Phone | Fax

Ordering Provider | NPI#

PATIENT DEMOGRAPHICS

PLEASE INCLUDE FACE SHEET. MISSING INFORMATION MAY DELAY TURNAROUND TIME AND REPORTING RESULTS.

First Name | MI | Last Name

Gender ☐ Male ☐ Female | Date of Birth

Phone | Social Security Number

Address | City, State, Zip

PATIENT INSURANCE

PLEASE INCLUDE COPY OF INSURANCE CARD

☐ Insurance ☐ Self Pay ☐ Client Bill

Primary Insurance: | Policy Number: | Group Number:

Secondary Insurance: | Policy Number: | Group Number:

Policy Holder Name: | Policy Holder DOB: | Policy Holder SSN:

Please Select a PGx Panel (tested genes shown below panel name):

Gene Variation Panel	Common ICD-10 Codes
☐ **PG01- Cardio PGx Panel** ABCB1, ABCG2, APOE, CYP2C, CYP2C8, CYP2C9, CYP2C19, CYP2D6, CYP3A4, CYP3A5, CYP4F2, F2, F5, ITGB3, MTHFR, SLCO1B1, VKORC1	___ **Z79.01**- Long term (current) use of anticoagulants ___ **I25.83** - Coronary atherosclerosis due to lipid rich plaque ___ **I25.84** - Coronary atherosclerosis due to calcified coronary lesion ___ **I25.89** - Other forms of chronic ischemic heart disease ___ **I25.9** - Chronic ischemic heart disease, unspecified ___ **I10** - Hypertension ___ **I49.9** - Cardiac arrhythmia ___ **I50.9** - Heart failure ___ **T45.615A** - Adverse effect of thrombolytic drugs I48.91 - Atrial fibrillation ___ **I25.6** - Silent myocardial ischemia ___ **I25.810** - Atherosclerosis of coronary artery bypass graft(s) w/o angina pectoris ___ **I20.8** - Other forms of angina pectoris
☐ **PG02 - Psychotropic PGx Panel** ADRA2, ANKK1, COMT, CYP1A2, CYP2B6, CYP2C9, CYP2C19, CYP2D6, CYP3A4, CYP3A5, DRD2, EPHX1, GRIK4, HTR2A, HTR2C, MTHFR, OPRM1, UGT2B15	___ **Z79.899** - Other long term (current) drug therapy ___ **F32.9** - Major depressive disorder, single episode, unspecified ___ **F33.9** - Major depressive disorder, unspecified ___ **F33.0** - Major depressive disorder, mild ___ **F33.1** - Major depressive disorder, moderate ___ **F33.4** - Major depressive disorder, in remission, unspecified ___ **F33.2** - Major depressive disorder, severe w/o psychotic features ___ **F33.3** - Major depressive disorder, severe w/ psychotic features ___ **F31.81** - Bipolar II disorder ___ **F31.9** - Bipolar disorder, unspecified ___ **F41.9** - Anxiety disorder, unspecified ___ **F90.9** - ADHD, unspecified type
☐ **PG03 - Oncology PGx Panel** CYP1A2, CYP2B6, CYP2C8, CYP2C9, CYP2C19, CYP2D6, CYP3A4, CYP3A5, DPYD, MTHFR, NUDT15, TPMT	___ **C61** - Malignant neoplasm of unspecified site, right female breast ___ **E04.9** - Nontoxic goiter ___ **G10** - Huntington's disease ___ **R11.2** - Nausea with vomiting ___ **C15.9** - Malignant neoplasm of esophagus ___ **C20** - Malignant neoplasm of rectum ___ **Z51.0** - Encounter for antineoplastic radiation therapy ___ **Z92.21** - Personal history of antineoplastic chemotherapy ___ **C34.90** - Malignant neoplasm of unspecified part of unspecified bronchus or lung ___ **C50.911** - Malignant neoplasm of unspecified site of right female breast
☐ **PG04 - Pain Management PGx Panel** COMT, CYP1A2, CYP2B6, CYP2C9, CYP2C19, CYP2D6, CYP3A4, CYP3A5, OPRM1	___ **Z79.891** - Long term (current) use of opiate analgesic ___ **Z79.899** - Other long term (current) drug therapy ___ **G10** - Huntington's disease ___ **G89.29** - Other chronic pain ___ **G89.4** - Chronic pain syndrome ___ **M12.9** - Arthropathy ___ **M15.9** - Polyosteoarthritis ___ **M79.7** - Fibromyalgia ___ **M25.50** - Pain in unspecified joint ___ **M25.569** - Pain in unspecified knee ___ **M54.5** - Low back pain ___ **M60.9** - Myositis, unspecified ___ **M79.1** - Myalgia ___ **M79.609** - Pain in unspecified limb
☐ **PG05 - Comprehensive Metabolic PGx Panel** ABCB1, ABCG2, ADRA2A, ADRB2, ANKK1, APOE, C11orf65, COMT, CYP1A2, CYP2B6, CYP2C, CYP2C8, CYP2C9, CYP2C19, CYP2D6, CYP3A4, CYP3A5, CYP4F2, DPYD, DRD2, EPHX1, F2, F5, GRIK4, HTR1A, HTR2A, HTR2C, ITGB3, MTHFR, NUDT15, OPRM1, SLC6A2, SLCO1B1, TPMT, UGT2B15, VKORC1	___ **D68.2** - Hereditary deficiency of other clotting factors ___ **I20.0** - Unstable angina ___ **I20.1**- Angina pectoris w documented spasm ___ **I21.9** - Acute myocardial infarction, unspecified ___ **I21.A1** - Myocardial infarction type 2 ___ **I21.A9** - Other myocardial infarction type ___ **I24.8** - Other forms of acute ischemic heart disease ___ **I25.5** - Ischemic cardiomyopathy ___ **I24.0** - Acute coronary thrombosis not resulting in myocardial infarction ___ **I24.1** - Dressler's syndrome ___ **I24.8** - Other forms of acute ischemic heart disease ___ **I25.5** - Ischemic cardiomyopathy ___ **I48.91** - Unspecified atrial fibrillation ___ **I82.91** - Chronic embolism and thrombosis, unspecified vein ___ **R03.0** - Elvtd blood pressure read, w/o diag of hypertension

Please list all additional ICD-10 Codes:

Please list all current patient medication:

APPLICATION OF RESULTS (check all that apply)

I, the medical provider, will utilize the test results as defined below:

☐ Prescribe clinical decision support for prescribing medications.

☐ Prescribe clinical decision support for avoiding or removing medications from existing regimen.

☐ Prescribe clinical decision support for dosing and titration.

☐ Prescribe clinical decision support for managing cardiovascular risk.

PATIENT CONSENT

I hereby declare that I am seeking laboratory testing willingly, and consent to provide the sample requested for laboratory testing. I understand both my right to refuse testing, and the impact refusal of testing may have on my treatment. I acknowledge that this agreement is valid and will remain valid unless revoked through written notification at any time. I delegate my right to insurance benefits in my name or on my behalf that may be payable to me from any insurance policy, self-insured plan, Medicare or Medicaid to the laboratory. Thus, I authorize payment directly to the laboratory, and understand that insurance acceptance does not relieve me from any responsibility concerning payment for laboratory services. I recognize that any payment I receive from my insurance provider for this laboratory service to be forwarded to the laboratory directly and immediately. Furthermore, I am aware of my financial responsibilities for all charges despite insurance coverage.

Patient Signature: _____ Date: _____

MEDICAL PROVIDER CONSENT

The results of this test are medically necessary for the diagnosis, risk assessment, or detection of illness, disease, symptom, disorder, or syndrome. This test will produce results that will support the management and treatment decisions for my patient's condition. I hereby indicate that I am the authorized healthcare provider and referring physician for this test. I have acknowledged and support the patient's right to refuse testing, and have offered the patient opportunities to ask questions as well as the opportunity to seek further counsel. The patient has chosen to take this test on their own accord and willingly selected FirmaLab Bio-diagnostics to perform this test. I acknowledge my responsibility as the patient's physician to record all applicable ICD-10 diagnosis codes.

Provider Signature: _____ Date: _____

PGx Medical Necessity Form

DEAR CLAIMS SPECIALIST:

This letter intends to both explain the medical necessity of the ordered test and as a formal request for full coverage of Molecular PGx, a pharmacogenomic multi gene variation panel that was prescribed for the patient (see listed below) by their healthcare provider (see below). The patient's sample will be used for pharmacogenomic testing by EIV Diagnostics, a CLIA-certified laboratory.

Using Molecular PGx in combination with patient medical history, clinical findings, and patient information will assist and offer guidance for patient-specific clinical decisions for medical management. Specifically, this test intends to avoid adverse drug reactions which can be costly and at times fatal. This test will also allow the physician to optimize drug dosing and better the precision and quality of successful treatment.

Molecular PGx testing will lead to a change in the management of the patient's condition and will eliminate the need for further testing by:

- Reducing trial-and-error in prescribing medications
- Precise selection of medication that is more effective, and has less side effects for the patient
- Increase patient medication and treatment adherence
- Eliminate potential associated costs from adverse drug reactions such as revisits, hospitalization, and changes of medications
- Selecting the correct medication and dose for the patient
- Reduce the need or frequency of tests associated with the patient's condition

The requested genetic testing is medically necessary for my patient for several reasons. The primary reason(s) for my request apply specifically to the patient listed below:

_____ Determine drug-gene interactions, determining how the patient will metabolize medications

_____ Reduce the number of medications that my patient is currently prescribed

_____ Aid in determining the potential effectiveness of medications prescribed to my patient

_____ Aid in determining the best course of therapy for my patient

_____ Avoid toxicity and adverse drug reactions

_____ Patient is not responding to the drugs he/she has been prescribed

_____ Other (please specify): _____

PLEASE SEE ATTACHED CLINICAL NOTES AND/OR ADDITIONAL INFORMATION PROVIDED

PATIENT INFORMATION	ORDERING PHYSICIAN INFORMATION
Full Legal Name:	Ordering Provider Name:
Date of Birth:	Ordering Provider NPI:
Date of Service:	Provider Signature:
ICD-10 Codes:	Date:

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EIV DIAGNOSTICS

Checklist of items to include with patient sample:

_____ **Physician Signature**

_____ **Patient Signature**

_____ Patient Demographics/Insurance Information

_____ Medications List

_____ Patient History/Physical

_____ Patient Office Notes/Progress Notes

_____ Medical Necessity Has Been Documented in Patient Notes

_____ Medical Necessity Form

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