PROMETHEUS®
Therapeutics & Diagnostics
For the person in every patient®

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www.prometheuslabs.com
A Nestlé Health Science Company

TEST REQUISITION

PLEASE PRINT

Laboratory / Account 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 NAME / ADDRESS

PHONE FAX

CONTACT

RESULTS ○ Mail ○ Fax ○ No results to lab

Patient Information (required)

LAST NAME

FIRST NAME MI

ADDRESS APT. NO.

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.

Provider Signature: _____ Date: _____

Billing Information (required)

BILL: ○ Provider Account ○ Insurance ○ Laboratory ○ Patient

○ **Medicare**: We will submit claims to Medicare for most of our services, but only for patients who are neither hospital inpatients nor hospital outpatients, for whom the hospital must submit a claim.

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 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 NUMBER

GROUP NAME GROUP NUMBER

ADDRESS

CITY STATE ZIP

PHONE FAX

POLICYHOLDER NAME

POLICYHOLDER ID# (SSN)

POLICYHOLDER DOB RELATION TO PATIENT

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-9 CODES (required)

CLINICAL DIAGNOSIS

PROMETHEUS TESTING ONLY. NO SUBSTITUTIONS.†

CHECK THE APPROPRIATE TEST(S) TO BE PERFORMED
(Specimen collection requirements on back)

IBD

☐ PROMETHEUS® **IBD sgi™ Diagnostic** - #1800
Includes serology, genetic and inflammation markers to help differentiate IBD vs. non-IBD and Crohn's disease vs. UC
Requires EDTA/Lavender Top Tube and Serum Tube

☐ PROMETHEUS® **IBD sgi Diagnostic** - #1800
Add PROMETHEUS® **Crohn's Prognostic** - #2001
If PROMETHEUS **IBD sgi Diagnostic** indicates Crohn's disease
Requires EDTA/Lavender Top Tube and Serum Tube

☐ PROMETHEUS® **IBD sgi Diagnostic** - #1800
Add PROMETHEUS® **Celiac Serology** - #1155
If PROMETHEUS **IBD sgi Diagnostic** indicates non-IBD
Requires EDTA/Lavender Top Tube and Serum Tube

☐ PROMETHEUS® **Crohn's Prognostic** - #2001
Includes serology and genetic markers to provide a patient's risk of future complications
Requires EDTA/Lavender Top Tube and Serum Tube

CELIAC

☐ PROMETHEUS® **Celiac PLUS** - #6360
Includes both antibody and genetic tests with risk stratification
☐ Tissue transglutaminase (tTG) IgA recombinant antigen - #1405
☐ Anti-endomysial (EMA) IgA - #1505 ☐ Total serum IgA - #1605
☐ DGP IgA - #1255 ☐ DGP IgG - #1355 ☐ HLA DQ2/DQ8

☐ PROMETHEUS® **Celiac Genetics** - #6260 (Genetics only)
Celiac genetic assessment HLA DQ2/DQ8 with risk stratification

☐ PROMETHEUS® **Celiac Serology** - #1155 (Serology only)
Includes the following:
• tTg IgA • EMA IgA • Total Serum IgA • DGP IgA • DGP IgG

THIOPURINE MGMT

☐ PROMETHEUS® **TPMT Genetics** - #3300
Genotype patients for individualized starting dose of thiopurines

☐ PROMETHEUS® **TPMT Enzyme** - #3320
Phenotype patients for individualized starting dose of thiopurines

☐ PROMETHEUS® **Thiopurine Metabolites** - #3200
Thiopurine metabolite (6-TGN, 6-MMPN) levels
Optimize ongoing dosing of thiopurines to reach and maintain therapeutic goal
Current therapeutic: ☐ 6-MP___mg/day ☐ AZA___mg/day ☐ Other___mg/day

ADD'L TESTS

☐ PROMETHEUS® **FIBRO*Spect*® II** - #4000

☐ PROMETHEUS® **Lacto*TYPE*®** - #6100
Lactose intolerance genetic assessment

☐ Other Prometheus Tests _____

ACKNOWLEDGMENT OF INFORMED GENETIC CONSENT REQUIRED FOR HIGHLIGHTED TESTS

†By using the 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.

SPECIMEN COLLECTION AND HANDLING PROCEDURES

Test Ordered (Turnaround Time from Date of Receipt)*	Specimen Requirements	Recommended Specimen Volume**	Specimen Storage / Stability***	Transportation Kit Requirement
PROMETHEUS® IBD sgi Diagnostic (3-4 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
PROMETHEUS® Crohn's Prognostic (4-7 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
PROMETHEUS® Celiac PLUS (PROMETHEUS Celiac Serology and PROMETHEUS Celiac Genetics) **(3 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
PROMETHEUS® Celiac Genetics (2-3 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
PROMETHEUS® Celiac Serology (2-3 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
PROMETHEUS® TPMT Genetics (2 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
PROMETHEUS® 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
PROMETHEUS® 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
PROMETHEUS® FIBROSpect® II (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
PROMETHEUS® 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

*Business days
**Note: Minimum specimen volume for genetic testing may vary with the WBC count.
***Frozen 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 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: (888) 423-5227 or go to www.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 of the following information is not required by the state in which I practice):

1. a statement that 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. a statement that 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. a statement that prior to signing the written consent a qualified medical 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. a statement that the patient was advised by a qualified medical professional of the risks and benefits of genetic testing and advised of the significance of a positive and a negative test result;
5. a statement that the patient understands that a positive test result is an indication that the patient may be predisposed to, or have, the condition listed above;
6. a statement that, if the results are positive, the patient understands that he/she may wish to consider further independent testing, consult his/her provider, or pursue genetic counseling;
7. a statement that the patient understands that the test may fail, that the results may be non-informative or not predictive for his/her case, and that these tests may reveal information that is unrelated to their intended purpose;
8. a statement that the patient understands that genetic testing offered at Prometheus is completely voluntary and is used to predict response to specific therapeutics and/or to provide information to aid in the treatment of gastrointestinal ailments and that no unauthorized testing is performed on the specimens;
9. a statement authorizing Prometheus to report his/her test results directly to the ordering provider;
10. a statement acknowledging that the genetic specimens will be destroyed within 60 days of test completion;
11. a statement that the written consent does not authorize the use or release of any other medical information unrelated to this genetic test; and
12. a statement that the patient understood that he/she could seek professional genetic counseling prior to signing this informed consent and undergoing the testing procedure and received written information identifying a genetic counselor or medical geneticist by his/her treating provider.