LABORATORY OF PERSONALIZED HEALTH

NPI: 1336325497

CLIA ID: 07D1036625
CT License: CL-0644
NY Permit: PFI 8648
RI License: LCO-00591
CA License: COS 00800405
FL License: 800026696

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HILO*met* + Thrombo*Net* TESTS REQUISITION & MEDICAL NECESSITY FORM

TO PATIENT: Please sign authorization form for genetic testing and insurance reimbursement.

Patient name _____ (FIRST NAME) _____ (INITIAL) _____ (LAST NAME) Patient date of birth _____

Patient address _____ CITY _____ STATE _____ ZIP _____

Patient gender
☐ Male ☐ Female

Patient ethnicity
☐ Caucasian ☐ Asian ☐ African American ☐ Hispanic

Name of Clinician requesting test: _____ NPI: _____

E-mail, Address, Telephone of Clinician ordering test(s): _____@_____

_____ (E-mail)
Street (_____) _____ - _____ (TEL)

_____ _____ _____ (_____) _____ - _____
City State Zip Code FAX

HILO*met* PhyzioType™ System, check ALL 3 boxes below:

☐ **HILO*met* 2C9** *(CYP 2C9)* [CPT Test Code: 81227]	☐ **HILO*met* 2C19** *(CYP 2C19)* [CPT Test Code: 81225]	☐ **HILO*met* 2D6** *(CYP 2D6)* [CPT Test Code: 81226]

Thrombo*Net* System, check ALL 4 boxes:

☐ **VKORC1** [CPT Test Code: 81355] *(requires **CYP 2C9**)*

☐ **Thrombo*Net* FII** *(Factor II)* [CPT Test Code: 81240]	☐ **Thrombo*Net* FV** *(Factor V)* [CPT Test Code: 81241]	☐ **Thrombo*Net* MTHFR** *(MTHFR)* [CPT Test Code: 81291]

ICD9 Diagnostic Codes *(Required)* _____

TO CLINICIAN: Establish MEDICAL NECESSITY for Referral; Document CLINICAL UTILITY of Tests *(Required).*

MEDICATION LISTS, CLINICAL NOTES ON ADVERSE DRUG REACTIONS OR INEFFICACY SHOULD BE ATTACHED.

What clinical characteristics of this Patient warrant referral for pharmacogenetic testing? *(√check)*

☐ **Drug intolerance and side effects**	☐ **Treatment resistance and lack of efficacy**
☐ **Treatment with multiple medications**	☐ **Elderly or infirm vulnerable patient**
☐ **Multiple medical conditions or hospitalization**	☐ **Family history of drug side effects**
☐ **History of thrombosis, DVT, embolism, VTE**	☐ **Hypercoagulable state (contraceptives, lupus)**

How will pharmacogenetic results directly change treatment or management of this Patient? *(√check)*

☐ **Selection of new prescription medication(s)**	☐ **Discontinuation of existing medication(s)**
☐ **Alternative dosing of existing medication(s)**	☐ **Adjustment of current multi-drug regimen**
☐ **Anti-coagulant, anti-thrombotic treatment**	☐ **Clarification of prior equivocal diagnostics**

Current Medication(s) _____

Intended Medication(s) _____

Signature _____ **Date** _____

PERSONALIZED HEALTH PORTAL: ***e-Reports + web-Interpretation,*** **Contact** *LPH@genomas.net*