ApolloGen
15375 Barranca Parkway, A105-106, Irvine, CA 92618
Phone: (949) 916-8886| Fax: (949) 916-8899
inquiries@apollogen.com
www.apollogen.com

PHARMACOGENOMICS TEST REQUISITION FORM

PATIENT INFORMATION

Patient Last Name: _____ Patient First Name: _____ MI_____

Date of Birth (MM/DD/YY): _____ Sex: ☐ Male ☐ Female ☐ Unknown

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____E-mail: _____

Ethnic Background (check all that apply)

☐ African American ☐ Asian/Pacific Islander

☐ Caucasian ☐ Hispanic ☐ Mediterranean

☐ Native American ☐ Other_____

REFERRING PHYSICIAN INFORMATION

Name (First Last): _____ Provider NPI#_____ Institution Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____E-mail: _____

Preferred Method of reporting: ☐ Website Portal ☐ Fax ☐ Mail ☐ Phone

Location ID:

SAMPLE INFORMATION

Date Collected: _____

Date Received: _____ (Lab Use Only)

Collected By: _____ Volume: _____

Sample Type: ☐ Blood (EDTA purple-top tube) ☐ Saliva

CLINICAL INFORMATION

Diagnosis/ICD-10 code: _____

_____

Current/ Intended Medication(s): _____

_____

BILLING INFORMATION

☐ **INSTITUTIONAL BILLING** Institution Name and Contact: _____

☐ **MEDICARE/MEDICAID** Medicare/Medicaid No. _____State: _____

☐ **INSURANCE BILLING** *Please include a copy of driver's license and insurance card(s) both front and back for billing purposes*

Policyholder Name _____ DOB (MM/DD/YY) _____ Phone Number_____

Insurance Co. _____ Member ID _____ Group No. _____

☐ **SELF PAYMENT** (Invoice for payment will be issued upon receipt of sample.)

Patient Acknowledgement for Financial Responsibility

I acknowledge that the information provided by me is true to the best of my knowledge. I hereby authorize my insurance benefits to be paid directly to ApolloGen, Inc. and authorize them to release medical information concerning my testing to my insurer. I understand that I am financially responsible for any amounts not covered by my insurer for this test order. I also fully understand that I am legally responsible for sending ApolloGen any money received from my health insurance company for the performance of this genetic test. Failing to do so will result in my account being sent to collection.

Patient's Name: _____ Patient's Signature:_____ Date:_____

SPECIMEN REQUIREMENT, SHIPPING INSTRUCTIONS AND SELECTED MEDICATION LIST ON THE BACK OF FORM

TEST REQUESTED *(Physician Use Only)*

☐ 1100 Comprehensive Pharmacogenomics (PGx) Panel

☐ 1110 Pain Management PGx Panel ☐ 1120 Mental Health PGx Panel

☐ 1130 Cardiovascular Health PGx Panel ☐ 1140 Thrombophilia Panel

Informed Consent and Statement of Medical Necessity

I have supplied information to the patient regarding genetic testing and the patient has given consent for genetic testing to be performed. I certify that the above pharmacogenomic test request is medically necessary as part of my treatment program for this patient. The prescribed pharmacogenomic test is reasonable and necessary for the treatment of the patient's condition and medical management. I authorize no substitutions for this test. This test to be reliable in assisting me in understanding a patient's reaction to medications and optimizes my treatment algorithm for patient care. I confirm that the person listed in the Ordering Physician space above is authorized by law to order the test(s) requested herein.

Physician's Name: _____ Physician's Signature:_____ Date:_____

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SPECIMEN COLLECTION AND SHIPPING INFORMATION	
Whole Blood	3-5 mL of whole blood in EDTA (purple-top/lavender-top) for routine tests. Blood samples should be sent by overnight shipping at room temperature as soon as possible after being drawn. If the specimen cannot be sent immediately, it should be stored refrigerated at 4°C. The blood specimen must not be stored for more than 5 days at 4°C.
Saliva	At least 2 mL of saliva sample should be collected with a Norgen Saliva DNA Collection Kit following the manufacturer's instructions. IMPORTANT: No eating, drinking, smoking or chewing gum 30 minutes prior to collection. Please contact us for a kit at (949)-916-8886 if necessary. Ship overnight at room temperature If the specimen cannot be sent immediately, it should be stored at room temperature.

- Please sterile technique for specimen collection and close all containers tightly. DO NOT FREEZE OR ADD FIXATIVE TO ANY SAMPLE.
- Please clearly label all containers with at least two patient identifiers (patient's name and date of birth), along with the collection date. Secure each specimen container tightly to avoid leakage in transit.
- Complete the test requisition with the patient's demographics and insurance information, including diagnosis/ICD-10 codes.
- Ship all samples by overnight courier or mail. Do not ship on Fridays. Samples may be received Monday-Friday, 8am-5pm. Call to alert the laboratory of pending shipment(s), or email the tracking number to us at inquiries@apollogen.com.
- Delivery address: ApolloGen Clinical Laboratory
  13766 Alton Parkway, Suite 147
  Irvine, CA 92618, USA.
- Please contact us for additional shipping materials, further instructions or any questions: 949-916-8886.

SELECTED COVERED DRUGS

*This is a **PARTIAL** list of the most commonly used drugs covered in our test. Contact us for the complete list.*

PAIN MANAGEMENT PANEL	CARDIOVASCULAR HEALTH PGX PANEL	MENTAL HEALTH PGX PANEL
Carisoprodol (Soma)	Azilsartan (Edarbi)	Donepezil (Aricept)
Celecoxib (Celebrex)	Irbesartan (Avapro)	Galantamine (Razadyne)
Naproxen (Aleve, Naprosyn)	Losartan (Cozaar)	Amitriptyline (Elavil)
Flurbiprofen (Ansaid)	Ranolazine (Ranexa)	Citalopram (Celexa)
Ibuprofen (Motrin)	Flecainide (Tambocor)	Desipramine (Norpramin)
Indomethacin (Indocin)	Propafenone (Rythmol)	Nortriptyline (Pamelor)
Meloxicam (Mobic)	Warfarin (Coumadin)	Paroxetine (Paxil, Brisdelle)
Midazolam (Versed)	Clopidogrel (Plavix)	Trimipramine (Surmontil)
Codeine (Codeine)	Carvedilol (Coreg)	Venlafaxine (Effexor)
Diclofenac (Voltaren)	Metoprolol (Lopressor)	Aripiprazole (Abilify)
Fentanyl (Actiq)	Propranolol (Inderal)	Clozapine (Clozaril)
Hydrocodone (Vicodin)	Torsemide (Demadex)	Sertraline (Zoloft)
Methadone (Dolophine)	Atorvastatin (Lipitor)	Olanzapine (Zyprexa)
Morphine (MS Contin)	Fluvastatin (Lescol)	Risperidone (Risperdal)
Oxycodone (Percocet)	Lovastatin (Mevacor)	Clobazam (Onfi)
Tramadol (Ultram)	Simvastatin (Zocor)	Diazepam (Valium)