Pharmacogenomics Test Requisition Form

GeneDx an OPKO Health Company

Patient Information

First name Last name
Gender ❒ Male ❒ Female Date of birth (mm/dd/yyyy) _____
Ancestry ❒ Caucasian ❒ Eastern European ❒ Central/South American
❒ Western European ❒ Native American ❒ Middle Eastern ❒ Hispanic
❒ African American ❒ Asian ❒ Pacific Islander ❒ Caribbean
❒ Ashkenazi Jewish ❒ Northern European ❒ Other: _____

Mailing address

City State Zip code

Home phone Work phone

Email Patient's primary language if not English

Sample Information

Medical record # Specimen ID Date sample obtained (mm/dd/yy)

❒ Blood in EDTA (5-6 mL in lavender top tube)

❒ DNA (>20 ug): Tissue source _____ concentration ___ (ug/ml) Vol ___(ul)

❒ Buccal Swab

❒ Other _____(call lab)

Patient has had a blood transfusion ❒ Yes ❒ No Date of last transfusion __/__/__
(2-4 weeks of wait time is required for some testing) Specimens are not accepted for patients who have had allogeneic bone marrow transplants.

Ordering Account Information

Acct # Account Name
Reporting Preference*. ❒ Care Evolve ❒ Fax ❒ Email
**If unmarked, we will use the account's default preferences or fax to new clients.*

Physician NPI #

Genetic Counselor

Street address 1

Street address 2

City State Zip code

Phone Fax (important)

Email Beeper

Send Additional Report Copies To:

Physician or GC/Acct # Fax#/Email/CE #

Physician or GC/Acct # Fax#/Email/CE #

Statement of Medical Necessity

This test is medically necessary and the results will determine my patient's medical management and treatment decisions. The person listed as the Ordering Physician is authorized by law to order the tests(s) requested herein. I confirm that I have provided genetic testing information to the patient and the patient has consented to genetic testing.

MD, DO or NPI Professional Signature (required) Date

Patient Consent (sign here or on the consent document)

I have read attached the Informed Consent document and I give permission to GeneDx to perform genetic testing as described. I also give permission for my specimen and clinical information to be used in de-identified studies at GeneDx to improve genetic testing and for publication, if appropriate. My name or other personal identifying information will not be used in or linked to the results of any studies and publications.I also give GeneDx permission to inform me or my health care provider in the future about research opportunities, including treatments for the condition in my family.

❒ Check this box if you are a New York state resident, and give permission for GeneDx to retain any remaining sample longer than 60 days after the completion of testing.

Patient/Guardian Signature Date

Pharmacogenomics Testing Options

❒ **J909 - PharmacoDx (~150 targeted variants for the following medication groups/disorders):** Antiarrhythmics, Anticoagulants, Antidepressants, Antidiabetics, Antiepileptics, Antihypertensives, Antipsychotics, Antivirals/Antiretrovirals, Benzodiazepines, Chemotherapeutics, Corticosteroids, General Anesthetics, Immunosuppressants, Inhibitors, Muscle Relaxants, NSAIDS, Opioids, Platelet Aggregation, Proton Pump Inhibitors, Statins, Stimulants

PATIENT STATUS – ONE MUST BE CHECKED: ❒ Hospital Inpatient ❒ Hospital Outpatient ❒ Not a Hospital Patient Hospital Patient Date of Discharge:_____

Payment Options

❒ Institutional Bill

GeneDx Account #

Hospital/Lab Name

Contact Name

Address

City State Zip Code

Phone Fax

❒ Patient Bill

Amount _____

I understand that my credit card will be charged the full amount for the testing.

Please bill my credit card (all major cards accepted)

❒ MasterCard ❒ Visa ❒ Discover ❒ American Express

Name as it appears on card

Account Number Expiration date CVC

Signature Date

For GeneDx Use Only

Informed Consent and Authorization Form

Account # Account Name

First Name Last Name Date of Birth (mm/dd/yy)

I understand that my health care provider has ordered the following genetic testing for {me/my child}:_____.

General Information About Genetic Testing

What is genetic testing?

DNA provides instructions for our body's growth and development. Genes are distinct sequences of DNA, and are arranged on chromosomes. The DNA in a gene contains instructions for making proteins, which determine things like growth and metabolism as well as traits like eye color and blood type. Genetic disorders are caused by changes in DNA or from changes in the structure or number of chromosomes. Genetic testing is a laboratory test that tries to identify these changes in chromosomes or the DNA. Genetic testing can be a diagnostic test, which is used to identify or rule out a specific genetic condition. Genetic screening tests are used to assess the chance for a person to develop or have a child with a genetic condition. Genetic screening tests are not typically diagnostic and results may require additional diagnostic testing.

GeneDx's PharmacoDx test aids health care providers in the selection of medications that are most likely to be effective and least likely cause side effects. Finding the right drug for patients while trying to manage side effects via a "trial and error method" can be time consuming, expensive, and may result in delayed treatment.

The purpose of this test is to obtain information on predicted drug response to medications based on my genetic makeup. Additional information about the specific test being ordered is available from my health care provider or I can go to the GeneDx website, www.genedx.com.

What could I learn from this genetic test?

The test results will include:

- Predicted response to certain medications, based on my genetic makeup
- Prescribing recommendations based on my predicted response to a medication
- A summary of the evidence behind the prescribing recommendations
- My genotype for each sequenced variant

What are the risks and limitations of this genetic test?

Genetic testing is highly accurate. Rarely, inaccurate results may occur for various reasons. These reasons include, but are not limited to: mislabeled samples, inaccurate reporting of clinical/medical information, rare technical errors, or unusual circumstances such as bone marrow transplantation, or the presence of change(s) in such a small percentage of cells that the change(s) may not be detectable by the test (mosaicism).

- This test does not have the ability to detect long-term medical risks that {I/my child} might experience. The result of this test does not guarantee my health or the health of my child.
- Occasionally, an additional sample may be needed if the initial specimen is not adequate.

Patient Confidentiality and Genetic Counseling

It is recommended that I consult with a physician, pharmacist, genetic counselor, and/or other health care professional before and after having this test. I can find a genetic counselor in my area here: www.nsgc.org. Further testing or additional consultations with a health care provider may be necessary.

To maintain confidentiality, the test results will only be released to the referring health care provider, to the ordering laboratory, to me, to other health care providers involved in {my/my child's} treatment, or to others as entitled by law. The United States Federal Government has enacted several laws that prohibit discrimination based on genetic test results by health insurance companies and employers. In addition, these laws prohibit unauthorized disclosure of this information. For more information, I understand that I can visit www.genome.gov/10002077.

International Specimens

If {I/my child} reside outside the United States, I attest that by providing a sample for testing, I am not knowingly violating any export ban or other legal restriction in the country of {my/my child's} residence.