PHARMACOGENETICS REQUISITION FORM

PRECHECK HEALTH SERVICES, INC.
100 Biscayne Blvd., Suite 1611, Miami FL 33132
Phone: (305)-203-4711 — **CLIA:** 10D2210020
appointment@precheckhealth.com — www.precheckhealth.com

PATIENT INFORMATION

First name | MI | Last name | Date of birth (MM/DD/YYYY)

Biological sex
☐ Male
☐ Femal

MRN (medical record number)

Ethnicity
☐ Asian ☐Black/African American ☐ White/Caucasian ☐ Ashkenazi Jewish ☐ Hispanic ☐ Other: _____

Email address (for billing contact and report access after clinician releases)

Mobile phone

Address

City | State/Prov | Zip/Postal code | Country

CLINICAL INFORMATION

Organization name | Phone | Fax

Address | City | State/Prov | ZIP/Postal Code | Country

CLINICAL TEAM

Primary clinical contact (contact for general inquires)

Name | NPI | Email address (for report access)

☐ INSURANCE BILLING (attach front and back of insurance card)

Attach clinical notes, medical records, and/or letter of medical necessity (LMN) to prevent delays. We do not accept insurance for certain tests or patients outside the US.

Policyholder name | Patient relationship to ☐Self ☐ Spouse ☐ Child Other: _____

Primary insurance company name | Primary member ID# | Primary insurance phone | Prior-authorization #

Secondary insurance company name | Secondary member ID# | Secondary insurance phone | Prior-authorization #

Medicare insurance billing only (select one):
☐ Patient was treated as a hospital inpatient in the last 14 days
☐ Not a hospital patient

☐ PATIENT PAY BILLING

PreCheck Health Services, Inc. will send an electronic invoice to the patient email listed above. Insurance will not be billed.

☐ INSTITUTIONAL BILLING

Precheck Health Services, Inc. will send an invoice to the organization address above. Please contact us if this order should be billed to a different location.

☐ PARTNERSHIP PROGRAMS

PreCheck Health Services, Inc. partner code:

Label each tube with the patient's full name, date of birth, and specimen collection date. A requisition form MUST accompany each specimen.

SPECIMEN INFORMATION

Collection date **(MM/DD/YYYY)**

If not provided, date will be 1 day prior to our receipt of specimen. For DNA, provide date retrieved from archive.

Specimen type

☐ Blood ☑ Buccal Swab

DNA must be extracted in a CLIA or other suitable certified laboratory. We are unable to accept blood or saliva from patients with allogeneic bone marrow transplants or a blood transfusion <2 weeks prior to specimen collection.

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Medical Necessity (Please check all that apply)

Test Rationale

- ☐ Patient has a history of medication failure(s)
- ☐ Patient has experienced adverse drug reaction sensitivity to prescribed medication(s)
- ☐ Patient has experienced lack of symptom relief from prescribed medication(s)
- ☐ There is a "Warning" in the Package Insert of the medication being considered
- ☐ Medication Class is new to the patient
- ☐ Desired medication for patient is a "Controlled Substance"
- ☐ An "Inhibitor" or "Inducer" may affect therapeutic response to prescribed medication
- ☐ Other: _____

Results Application:

- ☐ A component of my medical decision making for which medication(s) to avoid for this patient
- ☐ A component of my medical decision making as to which medication(s) to prescribe for this patient
- ☐ A component of my medical decision making regarding dose initiation or titration for this patient
- ☐ A component of my medical decision making to manage patient's cardio or thrombotic risk

Patient Profile (Clearly print medications below or attach separated list)

Medications under consideration affected by Pharmacogenomics*:

*required for Medicare Billing

1.	2.	3.	4.
5.	6.	7.	8.
9.	10.	11.	12.

Pharmacogenomics Gene List

☑ Select All genes,

- ☐ CFTR ☐ HLA-B ☐ CYP3A5 ☐ CYP2D6 ☐ APOE ☐ CYP2C19 ☐ HLA-A ☐ F5 ☐ COMT ☐ CYP1A2
- ☐ CYP2B6 ☐ CYP4F2 ☐ CYP2C9 ☐ SLCO1B1 ☐ F2 ☐ VKORC1 ☐ BCHE ☐ MTHFR ☐ CYP1A2

ADDITIONAL ICD CODES

_____

_____

_____

This list is intended to be used as a reference to assist ordering Physicians in providing ICD-10 Diagnosis Codes as required by Medicare and other insurers to determine the medical necessity of testing being ordered. This is not an exhaustive list of all applicable diagnoses. Physicians are not required to use these codes but should report the diagnostic codes that best describes the reason for performing the test based on individual patient diagnoses. It is the Physician's Responsibility to determine both the medical need for and the utilization of, all health care services ordered.

ICD -10 CODES THAT MAY APPLY

Group 1	E84.8	Cystic fibrosis with other manifestations
Group 2	B37.81	Candidal esophagitis
	B37.89	Other sites of candidiasis
	B44.0	Invasive pulmonary aspergillosis
	E16.4	Increased secretion of gastrin
	E31.20	Multiple endocrine neoplasia [MEN] syndrome, unspecified
	E31.8	Other polyglandular dysfunction
	F32.1	Major depressive disorder, single episode, moderate
	F32.2	Major depressive disorder, single episode, severe without psychotic features
	F32.3	Major depressive disorder, single episode, severe with psychotic features
	F32.4	Major depressive disorder, single episode, in partial remission
	F32.9	Major depressive disorder, single episode, unspecified
	F33.1	Major depressive disorder, recurrent, moderate
	F33.2	Major depressive disorder, recurrent severe without psychotic features
	F33.3	Major depressive disorder, recurrent, severe with psychotic symptoms
	F33.41	Major depressive disorder, recurrent, in partial remission
	F33.9	Major depressive disorder, recurrent, unspecified
	F40.01	Agoraphobia with panic disorder
	F40.11	Social phobia, generalized
	F41.0	Panic disorder [episodic paroxysmal anxiety]
	F41.1	Generalized anxiety disorder
	F43.11	Post-traumatic stress disorder, acute
	F43.12	Post-traumatic stress disorder, chronic
	F52.0*	Hypoactive sexual desire disorder
	F60.5	Obsessive-compulsive personality disorder
	G40.101	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, not intractable, with status epilepticus
	G40.109	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, not intractable, without status epilepticus
	G40.111	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, intractable, with status epilepticus
	G40.119	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, intractable, without status epilepticus
	G40.201	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, not intractable, with status epilepticus
	G40.209	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, not intractable, without status epilepticus
	G40.211	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, intractable, with status epilepticus
	G40.219	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, intractable, without status epilepticus
	G40.811	Lennox-Gastaut syndrome, not intractable, with status epilepticus
	G40.812	Lennox-Gastaut syndrome, not intractable, without status epilepticus
	G40.813	Lennox-Gastaut syndrome, intractable, with status epilepticus
	G40.814	Lennox-Gastaut syndrome, intractable, without status epilepticus
	G47.09	Other insomnia
	I20.0	Unstable angina
	I21.01	ST elevation (STEMI) myocardial infarction involving left main coronary artery
	I21.02	ST elevation (STEMI) myocardial infarction involving left anterior descending coronary artery
	I21.09	ST elevation (STEMI) myocardial infarction involving other coronary artery of anterior wall
	I21.11	ST elevation (STEMI) myocardial infarction involving right coronary artery
	I21.19	ST elevation (STEMI) myocardial infarction involving other coronary artery of inferior wall
	I21.21	ST elevation (STEMI) myocardial infarction involving left circumflex coronary artery
	I21.29	ST elevation (STEMI) myocardial infarction involving other sites
	I21.4	Non-ST elevation (NSTEMI) myocardial infarction
	I21.A1	Myocardial infarction type 2
	I21.A9	Other myocardial infarction type
	I22.0	Subsequent ST elevation (STEMI) myocardial infarction of anterior wall
	I22.1	Subsequent ST elevation (STEMI) myocardial infarction of inferior wall
	I22.2	Subsequent non-ST elevation (NSTEMI) myocardial infarction
	I22.8	Subsequent ST elevation (STEMI) myocardial infarction of other sites
	I25.2	Old myocardial infarction
	I69.30	Unspecified sequelae of cerebral infarction
	K21.00	Gastro-esophageal reflux disease with esophagitis, without bleeding
	K21.01	Gastro-esophageal reflux disease with esophagitis, with bleeding
	K21.9	Gastro-esophageal reflux disease without esophagitis
	K22.10	Ulcer of esophagus without bleeding
	K22.11	Ulcer of esophagus with bleeding
	K25.9	Gastric ulcer, unspecified as acute or chronic, without hemorrhage or perforation
	K26.6	Chronic or unspecified duodenal ulcer with both hemorrhage and perforation
	K26.7	Chronic duodenal ulcer without hemorrhage or perforation
	K26.9	Duodenal ulcer, unspecified as acute or chronic, without hemorrhage or perforation
	N95.8*	Other specified menopausal and perimenopausal disorders
	Z86.73	Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits
	Z98.61	Coronary angioplasty status
	Z98.62	Peripheral vascular angioplasty status

Group 3 & 4		
	C50.919*	Malignant neoplasm of unspecified site of unspecified female breast
	C50.929*	Malignant neoplasm of unspecified site of unspecified male breast
	F32.1	Major depressive disorder, single episode, moderate
	F32.2	Major depressive disorder, single episode, severe without psychotic features
	F32.3	Major depressive disorder, single episode, severe with psychotic features
	F32.4	Major depressive disorder, single episode, in partial remission
	F32.9	Major depressive disorder, single episode, unspecified
	F33.1	Major depressive disorder, recurrent, moderate
	F33.2	Major depressive disorder, recurrent severe without psychotic features
	F33.3	Major depressive disorder, recurrent, severe with psychotic symptoms
	F33.41	Major depressive disorder, recurrent, in partial remission
	F33.9	Major depressive disorder, recurrent, unspecified
	F40.01	Agoraphobia with panic disorder
	F40.11	Social phobia, generalized
	F41.0	Panic disorder [episodic paroxysmal anxiety]
	F41.1	Generalized anxiety disorder
	F43.11	Post-traumatic stress disorder, acute
	F43.12	Post-traumatic stress disorder, chronic
	F60.5	Obsessive-compulsive personality disorder
	F90.1	Attention-deficit hyperactivity disorder, predominantly hyperactive type
	F90.2	Attention-deficit hyperactivity disorder, combined type
	F90.8	Attention-deficit hyperactivity disorder, other type
	G47.09	Other insomnia
	G89.11	Acute pain due to trauma
	G89.18	Other acute postprocedural pain
	G89.29	Other chronic pain
	R11.2*	Nausea with vomiting, unspecified
	R52	Pain, unspecified
	Z48.89*	Encounter for other specified surgical aftercare
	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
	E75.22	Gaucher disease
	F11.23	Opioid dependence with withdrawal
	F20.0	Paranoid schizophrenia
	F20.1	Disorganized schizophrenia
	F20.2	Catatonic schizophrenia
	F20.3	Undifferentiated schizophrenia
	F20.5	Residual schizophrenia
	F20.81	Schizophreniform disorder
	F20.89	Other schizophrenia
	F31.0	Bipolar disorder, current episode hypomanic
	F31.11	Bipolar disorder, current episode manic without psychotic features, mild
	F31.12	Bipolar disorder, current episode manic without psychotic features, moderate
	F31.13	Bipolar disorder, current episode manic without psychotic features, severe
	F31.2	Bipolar disorder, current episode manic severe with psychotic features
	F31.31	Bipolar disorder, current episode depressed, mild
	F31.32	Bipolar disorder, current episode depressed, moderate
	F31.4	Bipolar disorder, current episode depressed, severe, without psychotic features
	F31.5	Bipolar disorder, current episode depressed, severe, with psychotic features
	F31.61	Bipolar disorder, current episode mixed, mild
	F31.62	Bipolar disorder, current episode mixed, moderate
	F31.63	Bipolar disorder, current episode mixed, severe, without psychotic features
	F31.64	Bipolar disorder, current episode mixed, severe, with psychotic features
	F31.71	Bipolar disorder, in partial remission, most recent episode hypomanic
	F31.73	Bipolar disorder, in partial remission, most recent episode manic
	F31.75	Bipolar disorder, in partial remission, most recent episode depressed
	F31.77	Bipolar disorder, in partial remission, most recent episode mixed
	F84.0	Major depressive disorder, single episode, moderate
	F95.2	Major depressive disorder, single episode, severe without psychotic features
	G10	Major depressive disorder, single episode, severe with psychotic features
	G24.01	Major depressive disorder, single episode, in partial remission
	G47.411	Major depressive disorder, single episode, unspecified
	G47.419	Major depressive disorder, recurrent, moderate
	I10	Major depressive disorder, recurrent severe without psychotic features
	I48.0	Major depressive disorder, recurrent, severe with psychotic symptoms
	I48.11	Major depressive disorder, recurrent, in partial remission
	I48.19	Major depressive disorder, recurrent, unspecified
	I50.1	Autistic disorder
	I50.20	Attention-deficit hyperactivity disorder, predominantly hyperactive type
	I50.30	Attention-deficit hyperactivity disorder, combined type
	I50.40	Attention-deficit hyperactivity disorder, other type
	I50.89	Tourette's disorder
	I50.9	Huntington's disease
	K21.00	Drug induced subacute dyskinesia
	K21.01	Narcolepsy with cataplexy
	K21.9	Narcolepsy without cataplexy
	K31.84*	Acute pain due to trauma
	M35.00	Other acute postprocedural pain
	N39.41*	Other chronic pain
	N39.46*	Essential (primary) hypertension
	R11.2	Paroxysmal atrial fibrillation
	R45.851*	Longstanding persistent atrial fibrillation
	T75.3XXA	Other persistent atrial fibrillation
	T75.3XXD	Left ventricular failure, unspecified
	T75.3XXS	Unspecified systolic (congestive) heart failure

Group 5		
	I21.9	Acute myocardial infarction, unspecified
	I22.9	Subsequent ST elevation (STEMI) myocardial infarction of unspecified site
	I23.6	Thrombosis of atrium, auricular appendage, and ventricle as current complications following acute myocardial infarction
	I25.2	Old myocardial infarction
	I26.02	Saddle embolus of pulmonary artery with acute cor pulmonale
	I26.09	Other pulmonary embolism with acute cor pulmonale
	I26.92	Saddle embolus of pulmonary artery without acute cor pulmonale
	I26.93	Single subsegmental pulmonary embolism without acute cor pulmonale
	I26.94	Multiple subsegmental pulmonary emboli without acute cor pulmonale
	I26.99	Other pulmonary embolism without acute cor pulmonale
	I48.11	Longstanding persistent atrial fibrillation
	I48.19	Other persistent atrial fibrillation
	I48.20	Chronic atrial fibrillation, unspecified
	I48.21	Permanent atrial fibrillation
	I51.3	Intracardiac thrombosis, not elsewhere classified
	I82.890	Acute embolism and thrombosis of other specified veins
	I82.891	Chronic embolism and thrombosis of other specified veins
	T82.817A	Embolism due to cardiac prosthetic devices, implants and grafts, initial encounter
	T82.817D	Embolism due to cardiac prosthetic devices, implants and grafts, subsequent encounter
	T82.817S	Embolism due to cardiac prosthetic devices, implants and grafts, sequela
	T82.818A	Embolism due to vascular prosthetic devices, implants and grafts, initial encounter
	T82.818D	Embolism due to vascular prosthetic devices, implants and grafts, subsequent encounter
	T82.818S	Embolism due to vascular prosthetic devices, implants and grafts, sequela
	T82.867A	Thrombosis due to cardiac prosthetic devices, implants and grafts, initial encounter
	T82.867D	Thrombosis due to cardiac prosthetic devices, implants and grafts, subsequent encounter
	T82.867S	Thrombosis due to cardiac prosthetic devices, implants and grafts, sequela
	T82.868A	Thrombosis due to vascular prosthetic devices, implants and grafts, initial encounter
	T82.868D	Thrombosis due to vascular prosthetic devices, implants and grafts, subsequent encounter
	T82.868S	Thrombosis due to vascular prosthetic devices, implants and grafts, sequela
	Z79.01	Long term (current) use of anticoagulants
	Z79.02	Long term (current) use of antithrombotics/antiplatelets
	Z86.711	Personal history of pulmonary embolism
	Z86.718	Personal history of other venous thrombosis and embolism
	Z86.79	Personal history of other diseases of the circulatory system
	Z95.2	Presence of prosthetic heart valve
	Z95.4	Presence of other heart-valve replacement
Group 6	Z94.0	Kidney transplant status
	Z94.1	Heart transplant status
	Z94.4	Liver transplant status
Group 7	C16.9	Malignant neoplasm of stomach, unspecified
	C18.9	Malignant neoplasm of colon, unspecified
	C19	Malignant neoplasm of rectosigmoid junction
	C20	Malignant neoplasm of rectum
	C25.9	Malignant neoplasm of pancreas, unspecified
	C50.919*	Malignant neoplasm of unspecified site of unspecified female breast
Group 8	E79.9*	Disorder of purine and pyrimidine metabolism, unspecified
Group 9	C43.9*	Malignant melanoma of skin, unspecified
	C77.9*	Secondary and unspecified malignant neoplasm of lymph node, unspecified
	K73.9*	Chronic hepatitis, unspecified
	K76.9*	Liver disease, unspecified
Group 10	C91.00	Acute lymphoblastic leukemia not having achieved remission
	C91.01	Acute lymphoblastic leukemia, in remission
	C91.02	Acute lymphoblastic leukemia, in relapse
	C92.00	Acute myeloblastic leukemia, not having achieved remission
	C92.01	Acute myeloblastic leukemia, in remission
	C92.02	Acute myeloblastic leukemia, in relapse
	M06.89	Other specified rheumatoid arthritis, multiple sites
	M06.8A	Other specified rheumatoid arthritis, other specified site
	Z94.0	Kidney transplant status

Patient Informed Consent for Genetic Testing

I, _____The Patient authorize PreCheck Health Services, Inc., to conduct genetic testing for IMMUNO GENETIC TEST (Disease and/or Test Name), as ordered by my physician or authorized healthcare provider or my child's or dependent's physician or autho-rized healthcare provider, and authorize the collection of a sample for the purpose of that testing.

I acknowledge and consent to the following:

1. My physician or his/her designee (such as a genetic counselor) has fully covered the following:

(A) purpose, description and nature of the test and its potential uses;
(B) reliability of positive or negative results and the level of certainty that a positive test result for the disease or condition serves as a predictor of such disease, the effectiveness and limitations of the genetic test and the meaning of the genetic test results;
(C) implications of taking the genetic test, including the medical risks and benefit;
(D) description of the disease or condition tested for;
(E) the availability and importance of genetic counseling. I acknowledge that I have been provided with information identifying a genetic counselor or medical geneticist from whom I might obtain such counseling and understand that I may seek counseling prior to signing this consent; and
(F) a positive test result is an indication that I may be predisposed to or have the specific disease or condition tested for and I understand that I may wish to consider further independent testing, consult with my physician or pursue genetic counseling to discuss the test results.

2. I authorize and I understand that I will receive the test results from my physician unless I direct otherwise. I understand that I have a right to confidential treatment of my sample and results and that my test results will only be disclosed as authorized in this consent.

3. Test results will be retained in accordance with applicable laws. I understand that only my physician's office and/or PreCheck Health Services, Inc. will have access to my sample and that my sample will be used only for the purposes for which I have given my consent.

Patient's Statement

I, the undersigned, have been informed about the test(s) purpose, procedures, possible beneÿts and risks, and I have received a copy of this consent. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask other questions at any time. I voluntarily agree to genetic testing.

PATIENT SIGNATURE*	SIGNATURE OF AUTHORIZED REPRESENTATIVE
PRINT NAME*	PRINT NAME
DATE*	DATE

By signing this form, the medical professional acknowledges that the individual/family member authorized to make decisions for the individual (collectively, the "Patient") has been supplied information regarding and consented to undergo genetic testing, substantially as set forth in PreCheck Health Services Inc. (PCHS) Informed Consent for Genetic Testing. For orders originating outside the US, the Patient has been informed their personal information and specimen will be transferred to and processed in the US. The Patient has been informed that PCHS may notify them of clinical updates related to genetic test results (in consultation with the ordering medical professional). If insurance billing is selected, the Patient has been informed and authorizes PCHS and its designed to release information concerning testing to their insurer. The medical professional agrees to allow PCHS (1) to transfer the information from this TRF to a letter of medical necessity and/or other documentation using the medical professional's name as the signature as well as (2) assist the patient in obtaining pre-test genetic counseling from a third-party service, as required by the patient's insurance provider. I acknowledge that the Patient has agreed that if the Patient's insurer does not reimburse PCHS in full for any reason then PCHS may bill the Patient for the services and the Patient will remit payment to PCHS For amounts the Patient receives from the insurer, the Patient has agreed to remit payment to PCHS for services rendered. I acknowledge that I offered pre-test genetic counseling to the Patient, if required by their insurer. I attest that I am authorized under applicable law to order this test.

ORDERING PHYSICIAN SIGNATURE*	DATE: (MM/DD/YYYY)

Patient Name: _____, Patient ID Number: _____
Notifier: PreCheck Health Services

Advance Beneficiary Notice of Non-Coverage (ABN) — All Insurance Providers

Notice to Patients: Your health insurance plan, whether Medicare or a commercial provider, may not cover all tests or services — including those that you and your healthcare provider consider medically necessary. This notice informs you that one or more of the following PreCheck Health tests may not be covered, and you may be financially responsible.

Tests That May Not Be Covered:

Test Category	Examples	Reason for non-coverage	Estimated Cost
PharmacoCheck+	Pharmacogenetic testing	Not deemed medically necessary for your diagnosis	Up to $295
Germline Custom Panels	ImmunoCheck+, CancerCheck+ NeuroCheck+, MetabolicCheck+ ThyroidCheck+, etc.…	Insurance exclusions, medical necessity, etc.	Up to $295

What You Need to Do:

1. Review this notice carefully to make an informed decision.
2. Ask any questions you may have before proceeding.
3. Select one of the options below to indicate your decision.

Note: If you select Option 1 or 2, we may attempt to coordinate with other insurance carriers you have. However, we are not required to do so by Medicare or other insurers.

Patient Options: (Please select only one option)

☐ Option 1: I want to receive the PreCheck Health Test(s) listed above. I understand that my insurance provider may not cover these services. I would like a claim submitted to my insurer for an official coverage decision. If denied, I agree to be responsible for payment. I understand that I may appeal the denial in accordance with my insurer's policies.

☐ Option 2: I want to receive the PreCheck Health Test(s) listed above. I do not want a claim submitted to my insurer. I agree to pay out of pocket and understand that I waive my right to an appeal through my insurance plan.

☐ Option 3: I do not want to receive the PreCheck Health Test(s) listed above. I understand that I will not be billed for the service and cannot appeal a non-coverage decision.

Additional Information:

-If you choose Option 1, PreCheck Health Services will attempt to contact you to discuss your eligibility for financial assistance and may provide you with the option to cancel your order before testing begins. If you have questions about your financial responsibility or coverage, please contact us at ***(305) 203-4711.***
-This form serves as a courtesy and does not represent an official decision by your insurance provider. If you have questions about your insurance policy or billing, contact your provider directly.
-For Medicare-specific questions, call ***1-800-MEDICARE*** (1-800-633-4227 / TTY: 1-877-486-2048).

Patient Acknowledgment:

By signing below, you confirm that you have received, reviewed, and understood this notice. You will also be provided with a copy for your records.

Signature of Patient or Authorized Representative: _____. Date: _____/_____/_____.