



Pharmacogenetic Requisition Form

Patient Information (required):

Name: _____

DOB (MM, DD, YR) ____/____/____ Gender ☐ Male ☐ Female

Street Address: _____

City, State, Zip: _____

Phone# _____

Imperium DNA Test Order – ☐

Provides a combinatorial genetic analysis showing the effect that multiple genes (*CYP2D6, CYP2C9, CYP2C19, CYP3A4/3A5, CYP1A2, Factor II, Factor V, MTHFR, OPRM1, SLCO1B1 and VKORC1*) may have on a patient’s ability to respond to any one of over 125 of the most commonly prescribed medications.

Practice Name _____

Address _____

☐ Provider _____ NPI # _____

☐ Provider _____ NPI # _____

DX Codes (Required)

List all relevant ICD-10 Codes:

- 1) _____ 2) _____
- 3) _____ 4) _____
- 5) _____ 6) _____

Payment Method

☐ Self Pay Medicare/ Tricare ☐ Medicaid ☐ ☐ Private

☐ Workman's Comp

 Injury Date ____ / ____ / ____ Employer _____

 Claim # _____

Insurance Information: (Required) – A CLEAR copy of the insurance card(s) front and back

Primary Insurance _____

Subscriber ID # _____

☐ Self ☐ Spouse ☐ Dependent ☐ Other

If patient is NOT primary insurance holder, please provide the following

Insured Name _____ Insured SSN _____ DOB ____/____/____

Patient Consent

I am voluntarily seeking laboratory services and hereby consent to provide a sample as requested. I have the right to refuse specific tests, but understand this may impact my treatment. This agreement can be revoked by me at any time with written notification and is valid until revoked. I hereby assign to the laboratory my right to insurance benefits that may be payable to me for services provided arising from any insurance policy, self-insured health plan, Medicare or Medicaid in my name or on my behalf. I further authorize payment of benefits directly to the laboratory. I understand acceptance of insurance does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether or not they are covered by my insurance. I understand that any payment I receive for services rendered by the laboratory from my insurance provider should be forwarded immediately to the laboratory.

Patient Signature (Required)

Medical Necessity

Specifically, the tests ordered herein are medically necessary for this particular patient, given the patient's clinical condition, because the tests assist in the: *(Must check at least one box, but may check more than one box)*

- ☐ Determination of efficacy of existing medications
- ☐ Assessment of patient's past adverse drug reaction.
- ☐ Assessment of potential adverse drug reaction based on one or more of the patient's attributes.
- ☐ Other: _____

Provider Signature (Required)