PROMETHEUS® Anser®

PROMETHEUS® Monitr™ Crohn's Disease

TEST REQUISITION

Prometheus Biosciences

PLEASE PRINT

SAMPLE COLLECTION INFORMATION

DATE COLLECTED (required):

TIME COLLECTED:

MEDICAL RECORD/PATIENT ID #:

SENDER SAMPLE ID #:

MEDICARE ONLY—HOSPITAL STATUS WHEN SAMPLE WAS COLLECTED:
☐ Hospital inpatient ☐ Hospital outpatient ☐ Non-hospital patient

LABORATORY/OTHER NAME/ADDRESS:

PHONE #: FAX #:

CONTACT:

RESULTS: ☐ Mail ☐ Fax ☐ No results to lab

PATIENT INFORMATION (REQUIRED)

LAST NAME:

FIRST NAME: MI:

ADDRESS: APT #:

CITY: STATE: ZIP:

HOME PHONE #: OTHER PHONE #:

DOB: SEX: ☐ M ☐ F SSN:

BILLING INFORMATION (REQUIRED)

BILL: ☐ Provider account ☐ Insurance ☐ Laboratory ☐ Patient

☐ **MEDICARE—MEDICAL NECESSITY NOTICE:** When ordering tests for which Medicare reimbursement will be sought, physicians (or other individuals authorized by law to order tests) should only order tests that are medically necessary for the diagnosis or treatment of a patient, rather than for screening purposes.

I certify that the ordered test(s) is/are reasonable and medically necessary for the diagnosis, care, and treatment of this patient's condition.

ORDERING PROVIDER'S SIGNATURE:

PRINT NAME: DATE:

PRIMARY INSURANCE: As a courtesy, we will bill your insurance. Please attach a copy (front and back) of insurance card(s) and complete all information below. **NOTE: Parent or guardian information is required if patient is a minor. Parent or guardian is responsible for payment.**

NAME OF PARENT OR GUARDIAN (IF PATIENT IS UNDER 18 YEARS OF AGE):

INSURANCE CARRIER: POLICY #:

GROUP NAME: GROUP #:

ADDRESS:

CITY: STATE: ZIP:

PHONE #: FAX #:

POLICYHOLDER NAME:

POLICYHOLDER ID # (SSN):

POLICYHOLDER DOB: RELATIONSHIP TO PATIENT:

SECONDARY INSURANCE: Attach a copy (front and back) of the secondary insurance card. Provide the insurance name, policy number and group name, billing address and phone, policyholder name, ID #, date of birth, relationship to patient, and phone number.

PREAUTH/REFERENCE #:

PROVIDER/ACCOUNT INFORMATION

ACCOUNT NAME/ADDRESS:

PHONE #: FAX #:

PROVIDER/NPI #:

ICD CODE(S) (required):

Primary Code			
1	2	3	4
5	6	7	8

CLINICAL DIAGNOSIS:

PLEASE PROVIDE PRIMARY REASON FOR ORDER FOR EACH TEST PERFORMED (select one reason per test)

MONITR REASON FOR ORDER:
- ☐ Baseline level following PROMETHEUS® IBD sgi®
- ☐ General baseline measurement
- ☐ Monitoring following treatment change
- ☐ General monitoring of disease activity/mucosal healing
- ☐ Loss of response

ANSER REASON FOR ORDER:
- ☐ Midinduction level
- ☐ Postinduction level
- ☐ Primary nonresponse
- ☐ Secondary loss of response
- ☐ Infusion/allergic reaction
- ☐ Maintenance (asymptomatic)
- ☐ Restart after drug holiday
- ☐ Side effects

MUST PROVIDE DOSAGE INFORMATION

INFUSION/INJECTION DATE: ____/____/____

DOSE: ____ mg **or** ____ mg/kg

FREQUENCY: Every ____ weeks

ROUTE OF ADMINISTRATION:

SELECT THE APPROPRIATE TEST TO BE PERFORMED

PLEASE PROVIDE ALL REQUIRED BILLING INFORMATION FOR EACH TEST ORDERED.

☐ PROMETHEUS **Anser ADA**—#3170
Simultaneously measures **adalimumab (ADA)** and antibodies-to-adalimumab (ATA) levels in serum.

☐ PROMETHEUS **Anser IFX**—#3150
Simultaneously measures **infliximab (IFX)** and antibodies-to-infliximab (ATI) levels in serum. Validated for use in patients treated with these medications.

Select medication: ☐ **REMICADE® (infliximab)** ☐ **INFLECTRA® (infliximab-dyyb)** ☐ **RENFLEXIS® (infliximab-abda)**

☐ PROMETHEUS **Anser UST**—#3190
Simultaneously measures **ustekinumab (UST)** and antibodies-to-ustekinumab (ATU) levels in serum.

☐ PROMETHEUS **Anser VDZ**—#3180
Simultaneously measures **vedolizumab (VDZ)** and antibodies-to-vedolizumab (ATV) levels in serum.

☐ PROMETHEUS **Monitr Crohn's Disease**—#7300
13 biomarkers to assess mucosal healing in Crohn's disease patients.
I acknowledge this patient has Crohn's disease.

Current medication:

If Monitr billing information differs from Anser, please select which entity should be billed for Monitr:
☐ Provider account ☐ Insurance ☐ Laboratory
☐ Patient ☐ Medicare

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Specimen collection requirements on back.

SPECIMEN COLLECTION AND HANDLING PROCEDURES

Test Ordered (Turnaround Time From Date of Receipt)[a]	Transportation Kit Requirements	Type of Specimen Required	Tube for Specimen Collection	Recommended Specimen Volume	Storage Conditions	Stability of Specimen
PROMETHEUS Anser ADA **PROMETHEUS Anser IFX** **PROMETHEUS Anser UST** **PROMETHEUS Anser VDZ** **(3 days)**	Refrigeration preferred, ship with cold pack	SERUM	Serum Separator Tube or Red-Top Tube	2.0 mL (0.5 mL for Peds)	Room temperature or refrigerate Do not freeze	Serum is stable for 7 days at room temp or 9 days refrigerated
PROMETHEUS Monitr Crohn's Disease **(3 days)**	Refrigeration preferred, ship with cold pack	SERUM	Serum Separator Tube or Red-Top Tube	2.0 mL Serum	Room temperature or refrigerate Do not freeze	Room temp: 24 hours Refrigerated: 7 days

[a]Business days.

Specimens should be labeled with 2 identifiers and date of collection. Examples of acceptable identifiers include, but are not limited to, patient name, date of birth, hospital number, and requisition, accession, or unique random number. Unlabeled specimens will not be accepted for testing.

SHIPPING INSTRUCTIONS: Prometheus has an agreement with FedEx® Express for priority overnight delivery service within the United States and Canada. Please call FedEx to schedule a pickup at 1-800-GoFedEx (463-3339). FedEx will pick up your specimens and ship them to Prometheus Laboratories Inc in San Diego at no expense to you. Prometheus will provide specimen transportation kits upon request.

NOTE: Multiple specimens may be shipped in a single transportation kit.

For more information, call Client Services at 888-423-5227, or go to www.prometheusbiosciences.com.

Prometheus tests are laboratory-developed tests that were developed and validated under Federal CLIA laboratory guidelines by Prometheus.

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