Personalized Prescribing Requisition Form
Physician Authorization - Patient Cash Pay

3101 Western Ave., Suite 100, Seattle, WA 98121 • Phone: 877.431.4362 • Fax: 206.219.4000 • CAP# 4344001 • CLIA# 50D0980559

PATIENT INFORMATION

Last Name | First Name | MI

Home Phone | Email

Street Address | City

State/Province/Region | Zip/Postal Code | Country Code

Date of Birth | Collection Date | Sex

Please check below:

☐ Blood transfusion within the last 90 days

☐ Liver, Bone Marrow, Stem Cell transplant (sample will be rejected)

PAYMENT INFORMATION

Credit Card Number

Expiration Date (MM/YY) | Type of Card (MasterCard, Visa, AMEX)

Name as It Appears on Credit Card

Card Billing Address

City | State/Province/Region | Zip/Postal Code

Please check below:

☐ Credit card information above

☐ Check enclosed for the full amount

☐ Prepaid by Web Order, confirmation#___________

PATIENT CONSENT

Lab Use Only Lab # R #

My signature below indicates I have read and agree to the Patient Consent on the back of this form. If patient is unable to sign, healthcare provider must obtain consent and write "incapable of consent, authorized by..." (Provider or guardian signs name).

Patient Signature: X **Date:**

PHYSICIAN ORDER & AUTHORIXATION

Signature and test selection required.

By signing, I confirm that: I ordered these test(s); ordered test(s) are medically necessary; I understand the benefits/limitations of the test(s) ordered; and I have conveyed the required information to the patient and obtained consent. I also authorize Genelex to provide test results to the patient. If the patient's medication list is attached, I give permission for a qualified Pharmacist to review and report to me when interaction risks are found. Signature stamp not allowed.

Signature **Date:**

TESTS (Select):

☐ **Genelex Polypharmacy Panel**
CYP2D6, CYP2C9, CYP2C19, CYP3A4, CYP3A5

☐ **Genelex Polypharmacy Comprehensive Panel**
CYP2D6, CYP2C9, CYP2C19, CYP3A4, CYP3A5, CYP4F2, ADRA2A, COMT, CYP1A2, CYP2B6, DPYD, F2, F5 Leiden, MTHFR, GRIK4, HLA-B*57:01, HTR2A, HTR2C, IFNL3 (IL28B), NAT2, OPRM1, SLCO1B1, TPMT, UGT1A1, VKORC1

INDIVIDUAL TESTS (Select):

☐ ADRA2A
☐ COMT
☐ CYP1A2
☐ CYP2B6
☐ CYP2C9
☐ CYP2C19
☐ CYP2D6
☐ CYP3A4
☐ CYP3A5
☐ CYP4F2
☐ DPYD (DPD)
☐ F2 (Factor II)
☐ F5 (Factor V) Leiden
☐ GRIK4
☐ HLA-B*57:01
☐ HTR2A
☐ HTR2C
☐ IFNL3 (IL28B)
☐ MTHFR
☐ NAT2
☐ OPRM1
☐ SLCO1B1
☐ TPMT
☐ UGT1A1
☐ VKORC1

PHYSICIAN INFORMATION

Physician Name (print) | NPI#

Facility

Address | City | State/Province/Region | Zip/Postal Code

Phone | Fax | Email*

Results Sending Preference (please check one or more): ☐ Fax ☐ Email ☐ Mail

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INDIVIDUAL TESTS BY SPECIALIZATION

Drug Metabolizing Enzymes
- ☐ CYP1A2
- ☐ CYP2B6
- ☐ CYP2C9
- ☐ CYP2C19
- ☐ CYP2D6
- ☐ CYP3A4
- ☐ CYP3A5
- ☐ CYP4F2 (warfarin)

Psychotropic
- ☐ GRIK4 (citalopram)
- ☐ HTR2A (SSRIs, non-SSRIs, antipsychotics)
- ☐ HTR2C (antipsychotics)

Cardiology
- ☐ APOE
- ☐ F2 (Factor II)
- ☐ F5 (Factor V Leiden)
- ☐ MTHFR
- ☐ SLCO1B1 (statins)
- ☐ VKORC1 (warfarin)

High Risk Drugs
- ☐ HLA-B*57:01 (abacavir)
- ☐ TPMT (thiopurines)
- ☐ DPYD / DPD (fluoropyrimidines)

Miscellaneous
- ☐ ADRA2A (methylphenidate)
- ☐ COMT (catecholamine neurotransmitters)
- ☐ IFNL3 / IL28B (PEG-interferon-α drugs)
- ☐ NAT2 (acetylators, sulfa, chemical carcino-gens)
- ☐ OPRM1 (opioids)
- ☐ UGT1A1 (Irinotecan)

PATIENT PROFILE

Clearly print medication list or attach electronic health record

Current Medications, Supplements and Herbals:

1.	11.
2.	12.
3.	13.
4.	14.
5.	15.
6.	16.
7.	17.
8.	18.
9.	19.
10.	20.

Ineffective medications incuding drugs you are allergic to:

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

Patient Consent

I consent to the collection of specimens from myself (or individual who lacks capacity for consent) for the purpose of DNA testing. I understand that the Genelex Drug Sensitivity tests help healthcare providers identify the safest, most effective medications for me and which ones to avoid. I understand this is done with a combination of 1) genetic testing that determines how the body metabolizes or responds to the majority of medications, 2) patented software that predicts how genetics, other drugs and supplements alter drug levels, and 3) guidance from clinical professionals. I understand that a positive (abnormal) test result usually means that I may be at risk for a condition. I understand that test results may be negative even if I have a genetic condition because genetic markers that are not being tested or yet discovered are not detected. I understand that genetic test results may be unclear or difficult to interpret due to current understanding of genetic disorder or condition and/or technical limitations of the test and that the results are not intended to be used as the sole means for clinical diagnosis or patient care decisions. Predicted gene function may change depending upon the emergence of new discoveries, literature, industry standards and guidelines. I may want to have genetic counseling prior to signing this consent or after testing. No tests other than those authorized by my doctor shall be done.

I understand that: while DNA testing is highly accurate and widely accepted, as in all testing there is a possibility of delay or error; prescription drug regimens should never be altered without consulting a prescribing medical professional; Genelex may use reference laboratories; Genelex may contact me to obtain additional specimens for testing; and Genelex maintains patient privacy according to HIPAA. I understand that after personal information is removed, the data/specimen may be stored indefinitely to be used for quality assurance, studies or medical education. I may request disposal of my sample up to 60 days after the completion of my test by contacting the laboratory (New York State residents: sample shall be destroyed within 60 days of collection). I agree to relinquish Genelex, YouScript Inc. and its representatives from liability for injury that may arise from collecting and testing these specimens and from any effects or actions that the results of these tests may have on me or any other individual. I have been given the opportunity to ask questions regarding purpose, test reliability/ limitations, risks and benefits. I understand that genetic tests can involve possible medical, psychological or insurance issues for me. My participation in this genetic testing is completely voluntary and I understand my results will be sent to myself and the ordering physician or facility.

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