MINERVA LABS

1203 S WHITE CHAPEL SUITE 150
SOUTHLAKE, TEXAS 76092
Phone: +1 965-279-2091
EMAIL: INFO@MINERVALABS.HEALTH
WEBSITE: WWW.MINERVALABS.HEALTH

PHARMACOGENOMICS TEST REQUISITION

INSTRUCTIONS

- Patient and Physician must sign the consent form
- All items identified as '***Required***' must be provided/attached to the requisition form.

SUBMISSION CHECKLIST

- ☐ SOAP notes and progress notes
- ☐ Patient insurance ID card or face sheet
- ☐ Physician and Patient Signature

Ordering Physician Information

Physician Name	NPI#	FAX#
Office/Practice/Institution Name	Physician's Email	
Street Address		
City	State	Zip Code
Office Contact Name	Contact Phone	Contact Email

Ordering Provider (Please select one physician per order)

Physician name: ..... Physician NPI: ..... Physician name: ..... Physician NPI: .....

Physician name: ..... Physician NPI: ..... Physician name: ..... Physician NPI: .....

PATIENT INFORMATION

REQUIRED

Patient First Name	Patient Last Name	Date of Birth (mm/dd/yyyy)	Phone Number
Address	City	State	Zip

Gender Identity

- ☐ Male
- ☐ Female
- ☐ Female-to-Male
- ☐ Male-to-Female
- ☐ Genderqueer
- ☐ Other (Specify) .....
- ☐ Choose not to Disclose

Sexual Orientation

- ☐ Lesbian, gay, or homosexual
- ☐ Straight or heterosexual
- ☐ Bisexual
- ☐ Something else (Describe) .....
- ☐ Choose not to disclose

Ancestry

- ☐ White/Caucasian
- ☐ Native American
- ☐ Hispanic
- ☐ African American
- ☐ Ashkenazi Jewish
- ☐ Middle Eastern
- ☐ American Indian
- ☐ Asian
- ☐ Native Hawaiian and Other Pacific Islander

PAYMENT OPTIONS (SELECT ONE)

REQUIRED

- ☐ Insurance Billing (Please provide the insurance information)
- ☐ Self-Pay (Please provide credit card details or mail the check to the laboratory address)
- ☐ Client Billing / Institutional Billing

Primary Insurance	Insurance Policy/ID#	Group
Primary Policy Holder Name	Date of Birth	
Secondary Insurance	Insurance Policy/ID#	Group
Secondary Policy Holder Name	Date of Birth	

SPECIMEN INFORMATION

REQUIRED

Sample Type

☐ Buccal Swab ☐ Extracted DNA

Sample Draw Date (mm/dd/yyyy)

...../...../.....

Shipping Instructions

- Label each specimen tube with the patient's full name and date of birth or patient's full name and collection date.
- To receive the specimen requirements and shipping guidelines, please send an email to - **info@minervalabs.health**

Send completed Requisition form with collected sample to:
1203 South White Chapel STE 150,

Southlake,Texas 76092

COMPREHENSIVE PGX PANEL

REQUIRED

☐ ACE	☐ CACNA1C	☐ CYP2A13	☐ CYP2D6	☐ CYP3A5	☐ F2	☐ HTR2C	☐ NUDT15	☐ TPMT
☐ AGTR1	☐ CACNA1S	☐ CYP2B6	☐ CYP2F1	☐ CYP3A	☐ F5	☐ IFNL3	☐ OPRM1	☐ UGT1A1
☐ APOB	☐ CFTR	☐ CYP2C8	☐ CYP2J2	☐ CYP3A43	☐ GRIK4	☐ ITGB7	☐ RYR1	☐ UGT1A9
☐ APOE	☐ COMT	☐ CYP2C9	☐ CYP2R1	☐ CYP4F2	☐ HCP5	☐ LDLR	☐ SLC28A3	☐ VKORC1
☐ ATM	☐ CYP1A2	☐ CYP2C19	☐ CYP3A4	☐ DPYD	☐ HTR2A	☐ MTHFR	☐ SLCO1B1	☐ HLA-B
								☐ GLP1R

COMMONLY USED ICD10 (DIAGNOSIS) CODES

REQUIRED

please note, the icd-10 codes herein are solely for informational use. it is incumbent upon order practitioners to the diagnosis code that precisely justifies test conduct, regardless of its presence in the subsequent list.

COLUMN 1

- ☐ **F11.23** Opioid dependence with withdrawal
- ☐ **F20.81** Schizophrenia, unspecified
- ☐ **F31.12** Bipolar disorder, current episode manic without psychotic features, moderate
- ☐ **F31.32** Bipolar disorder, current episode depressed, moderate
- ☐ **F31.61** Bipolar disorder, current episode mixed, moderate
- ☐ **F84.0** Autistic disorder
- ☐ **F90.1** Attention-deficit hyperactivity disorder, predominantly inattentive type
- ☐ **F90.2** Attention-deficit hyperactivity disorder, combined type
- ☐ **F90.8** Other Attention-deficit hyperactivity disorder
- ☐ **G47.419** Restless legs syndrome, unspecified
- ☐ **G89.11** Acute pain due to trauma
- ☐ **G89.29** Other chronic pain
- ☐ **I10** Essential (primary) hypertension
- ☐ **I48.0** Paroxysmal atrial fibrillation
- ☐ **I48.11** Long-standing persistent atrial fibrillation
- ☐ **I50.20** Unspecified systolic (congestive) heart failure
- ☐ **I50.30** Unspecified diastolic (congestive) heart failure
- ☐ **I50.40** Combined systolic (congestive) and diastolic (congestive) heart failure
- ☐ **I50.89** Other heart failure
- ☐ **I50.9** Heart failure, unspecified
- ☐ **K31.84** Gastric mucosal hypertrophy
- ☐ **R11.2** Nausea with vomiting, unspecified
- ☐ **R45.851** Suicidal ideations
- ☐ **R52** Pain, unspecified
- ☐ **T75.3XXA** Effects of lightning, initial encounter
- ☐ **T75.3XXS** Effects of lightning, sequela

COLUMN 2

- ☐ **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
- ☐ **F32.9** Major depressive disorder, single episode, unspecified
- ☐ **F33.1** Major depressive disorder, recurrent, moderate
- ☐ **F33.2** Major depressive disorder, recurrent severe without psychotic features
- ☐ **F33.41** Major depressive disorder, recurrent, in partial remission
- ☐ **F33.9** Major depressive disorder, recurrent, unspecified
- ☐ **G40.219** Epilepsy, unspecified, not intractable, without status epilepticus
- ☐ **G47.09** Other insomnia not due to a substance or known physiological condition
- ☐ **I21.A9** Other type of myocardial infarction
- ☐ **F41.0** Panic disorder [episodic paroxysmal anxiety] without agoraphobia
- ☐ **F41.1** Generalized anxiety disorder
- ☐ **F43.11** Post-traumatic stress disorder, acute
- ☐ **F43.12** Post-traumatic stress disorder, chronic
- ☐ **I25.2** Old myocardial infarction
- ☐ **F60.5** Anankastic personality disorder
- ☐ **K21.00** Gastro-esophageal reflux disease without esophagitis
- ☐ **K21.9** Gastro-esophageal reflux disease without esophagitis or with unspecified esophagitis Ulcer of esophagus without bleeding
- ☐ **K22.10** Ulcer of esophagus with bleeding
- ☐ **K22.11** Epilepsy, unspecified, not intractable, with status epilepticus
- ☐ **G40.209** Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits
- ☐ **Z86.73** Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, intractable, with status epilepticus
- ☐ **G40.211**

COLUMN 3

- ☐ **M06.8A** Other specified rheumatoid arthritis, other specified site
- ☐ **E78.00** Pure hypercholesterolemia, unspecified
- ☐ **E78.01** Familial hypercholesterolemia
- ☐ **Z86.39** Personal history of other diseases of the circulatory system
- ☐ **E78.1** Pure hyperglyceridemia
- ☐ **E78.2** Mixed hyperlipidemia
- ☐ **E78.49** Other hyperlipidemia

Additional ICD Codes:

PATIENT CONSENT

By signing this form, I acknowledge that the information provided by me is true and correct. I have read or have had read to me the **Minerva Labs** Informed Consent document at the end of this test requisition form, and understand the information regarding molecular genetics testing. For direct insurance billing: I authorize my insurance benefits to be paid directly to **Minerva Labs** and their affiliates, authorize **Minerva Labs** to release medical information concerning my testing to my insurer, to be my designated representative for purposes of appealing any denial of benefits as needed and to request additional medical records for this purpose. I understand that I am financially responsible for any amounts not covered by my insurer and responsible for sending **Minerva Labs** and their affiliates, money received from my health insurance company. I also give permission for my specimen and clinical information to be used in de-identified studies at **Minerva Labs**and their affiliates for publication, if appropriate. I have had the opportunity to ask questions about the testing, the procedure, the risks, and the alternatives. I authorize **Minerva Labs** and their affiliates to perform the testing as ordered.

REQUIRED

Signature Date

Certificate of medical necessity, Consent, Test Authorization and Physician Signature

The individual signing this form, or their representative, hereby confirms their status as a licensed medical professional authorized to order genetic testing and confirms that the patient has provided informed consent for the testing and that it is medically necessary. They certify that any custom panel and/or ordered test(s) requested on this test requisition form are reasonable and medically necessary for the diagnosis and/or treatment of a disease, illness, impairment, symptom, syndrome, or disorder. They acknowledge that the test results may have an impact on the patient's medical management. The information provided on this form is accurate to the best of their knowledge. The signature on this form applies to the attached letter of medical necessity. If the insurance provider requests the laboratory to gather the medical necessity for any reason, the signer agrees to provide the Care Plan notes and Letter of Intent for this order.

Signature Date