

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 #: _____

9410 Carroll Park Drive, San Diego, CA 92121

www.prometheuslabs.com • Toll-free: 888-423-5227 • Phone: 858-824-0895 • Fax: 877-816-4019

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 monitoring of disease activity/mucosal healing
 General baseline measurement
 Monitoring following treatment change Loss of response

ANSER REASON FOR ORDER:

Midinduction level Secondary loss of response Restart after drug holiday
 Postinduction level Infusion/allergic reaction Side effects
 Primary nonresponse Maintenance (asymptomatic)

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)** **RENFLIXIS® (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

Specimen collection requirements on back.

ADA19003 08/19 V3

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 <u>Do not freeze</u>	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 <u>Do not freeze</u>	Room temp: 24 hours Refrigerated: 7 days

^aBusiness 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.prometheuslabs.com.

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