

SAMPLE COLLECTION INFORMATION

DATE COLLECTED (required): _____
 TIME COLLECTED: _____
 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: We will submit claims to Medicare for most of our services, but only for patients who are neither hospital inpatients nor hospital outpatients, for whom the hospital must submit a claim.

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 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 _____ RELATION 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, relation to patient, and phone number.

PREAUTH/REFERENCE #: _____

PROVIDER/ACCOUNT INFORMATION

ACCOUNT NAME / ADDRESS _____

PHONE _____ FAX _____

PROVIDER / NPI# _____

ICD CODES (required)

CLINICAL DIAGNOSIS _____

REASON FOR ORDER:
 Loss of response Infusion/allergic reaction Restart after drug holiday
 Relapse Disease monitoring Side effects

CHECK THE APPROPRIATE TEST(S) TO BE PERFORMED
 MUST CHECK BOX ON LEFT NEXT TO TEST BEING ORDERED

ANSER ADA

PROMETHEUS® Anser® ADA - #3170
 Simultaneously measures **adalimumab (ADA)** and antibodies to adalimumab (ATA) levels in serum.
CURRENT INJECTION DATE: ____/____/____
ADALIMUMAB DOSE: 40 mg 80 mg 160 mg Other dose: ____ mg
FREQUENCY: Every week Every 2 weeks Every 3 weeks
 Other frequency: Every ____ weeks

ANSER IFX

PROMETHEUS® Anser® IFX - #3150
 Simultaneously measures **infliximab (IFX)/infliximab biosimilar** and antibodies to infliximab (ATI) levels in serum.
SELECT MEDICATION: **REMICADE® (INFLIXIMAB)** **INFLIXIMAB BIOSIMILAR**
Anser® IFX has been validated for use in patients treated with infliximab biosimilars.
CURRENT INFUSION DATE: ____/____/____
INFLIXIMAB DOSE: 5 mg/kg 10 mg/kg Other dose: ____ mg/kg
FREQUENCY: Every 4 weeks Every 6 weeks Every 8 weeks
 Every 12 weeks Other frequency: Every ____ weeks

ANSER VDZ

PROMETHEUS® Anser® VDZ - #3180
 Simultaneously measures **vedolizumab (VDZ)** and antibodies to vedolizumab (ATV) levels in serum.
CURRENT INFUSION DATE: ____/____/____
VEDOLIZUMAB DOSE: 300 mg Other dose: ____ mg
FREQUENCY: Every 2 weeks Every 4 weeks Every 6 weeks Every 8 weeks
 Other frequency: Every ____ weeks

Specimen collection requirements on back.

SPECIMEN COLLECTION AND HANDLING PROCEDURES

Test Ordered (Turnaround Time From Date of Receipt)*	Transportation Kit Requirements	Type of Specimen Required	Tube for Specimen Collection	Recommended Specimen Volume	Storage Conditions	Stability of Specimen
PROMETHEUS® Anser® ADA (3 days)	Cold pack acceptable but not required	SERUM	Serum Separator Tube or Red Top Tube	2.0 mL (0.50 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® Anser® IFX (3 days)	Cold pack acceptable but not required	SERUM	Serum Separator Tube or Red Top Tube	2.0 mL (0.50 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® Anser® VDZ (3 days)	Cold pack acceptable but not required	SERUM	Serum Separator Tube or Red Top Tube	2.0 mL (0.50 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

*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: (888) 423-5227 or go to www.prometheuslabs.com

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