PROMETHEUS®
Anser™ADA

PROMETHEUS™
Anser™IFX

TEST REQUISITION
PLEASE PRINT

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

PROVIDER / ACCOUNT INFORMATION

ACCOUNT NAME / ADDRESS

PHONE FAX

PROVIDER / NPI #

ICD-9 CODES (required)

CLINICAL DIAGNOSIS

PATIENT INFORMATION (REQUIRED)

LAST NAME

FIRST NAME MI

ADDRESS APT. NO.

CITY STATE ZIP

HOME PHONE # OTHER PHONE #

DOB SEX ☐ M ☐ F SSN

TEST REQUESTED
(Specimen Collection Requirements On Back)

☐ 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.

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 NUMBER

GROUP NAME GROUP NUMBER

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 #:

ADDITIONAL INFORMATION

REASON FOR ORDER:

☐ Loss of response
☐ Relapse
☐ Disease monitoring
☐ Infusion / allergic reaction
☐ Restart after drug holiday
☐ Side effects

ANSER ADA

PRIOR DOSE AND INJECTION INTERVAL:

DATE: / /

ADALIMUMAB DOSE / FREQUENCY:
☐ 40 mg ☐ 80 mg ☐ 160 mg
☐ Every week ☐ Every 2 weeks

CURRENT DOSE AND INJECTION INTERVAL:

DATE: / /

ADALIMUMAB DOSE / FREQUENCY:
☐ 40 mg ☐ 80 mg ☐ 160 mg
☐ Every week ☐ Every 2 weeks

ANSER IFX

PRIOR DOSE AND INFUSION INTERVAL:

DATE: / /

INFLIXIMAB DOSE / FREQUENCY:
☐ 5 mg/kg ☐ 10 mg/kg
☐ Every 8 weeks ☐ Every 6 weeks
☐ Every 4 weeks

CURRENT DOSE AND INFUSION INTERVAL:

DATE: / /

INFLIXIMAB DOSE / FREQUENCY:
☐ 5 mg/kg ☐ 10 mg/kg
☐ Every 8 weeks ☐ Every 6 weeks
☐ Every 4 weeks

PROMETHEUS®
Therapeutics & Diagnostics
For the person in every patient™
A Nestlé Health Science Company

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