TEST REQUISITION FORM - ONCOLOGY

PGx Panels

CTLPGX

fulgent Oncology

P +1 888.354.8168 | F +1 855.856.0655 | info@fulgentoncology.com

CLIENT NAME/ID (FOR LAB USE): _____

Highlighted fields are required information*

PATIENT INFORMATION

LAST NAME* | FIRST NAME*

SEX ASSIGNED AT BIRTH* ◯ Male ◯ Female ◯ Unknown | DATE OF BIRTH (MM/DD/YYYY)*

MRN | ETHNICITY

ADDRESS

CITY | STATE | POSTAL CODE | COUNTRY

PHONE | EMAIL

PATIENT ACKNOWLEDGEMENT

I have read the Informed Consent document and I give permission to Fulgent Genetics and its entities to perform genetic testing as described. I also give permission for my specimen and clinical information to be used in de-identified studies at Fulgent and for publication, if appropriate. My name or other personal identifying information will not be used in or linked to the results of any studies and publications. More information is available at **www.fulgentgenetics.com/policies/privacy-policy.**

☐ Check this box if you are a New York state resident and give permission for Fulgent to retain any remaining sample longer than 60 days after sample collection.

☐ Opt out of research

X _____ Patient Signature (Required for billing purposes)* | Date (MM/DD/YYYY)

ORDERING PROVIDER

INSTITUTION/PRACTICE NAME

INSTITUTION PHONE / FAX | INSTITUTION EMAIL

ORDERING PROVIDER(S)

NPI (USA)/MINC (Canada) | PROVIDER TITLE (MD, DO, GC)

PROVIDER ADDRESS

CITY | STATE | POSTAL CODE | COUNTRY

PROVIDER PHONE | FAX/EMAIL REPORT TO

STATEMENT OF INFORMED CONSENT

By signing below, I, the ordering Medical Provider, confirm that testing is medically necessary and that test results may impact medical management for the patient.

I attest that the patient has received and read the Fulgent Informed Consent document, or has had it read to them, and that I have fully informed the patient about the purpose, capabilities, and limitations of the ordered test. The patient has voluntarily given his or her full consent for the ordered test and a signed copy of this consent is available on file. Any Fulgent Informed Consent that the patient agrees to at a later date will supersede and replace this Informed Consent.

X _____ Ordering Provider Signature (Required)* | Date (MM/DD/YYYY)

PATIENT COMMUNICATION CONSENT

☐ By checking this box, you acknowledge and agree that:

a. By executing this agreement, you are providing express written consent for Fulgent, CSI, and Inform Diagnostics, their affiliates and subsidiaries, and parties making contact on their behalf to call and text you using automatic telephone dialing systems and artificial or pre-recorded messages at the telephone number you have provided, about your out-of-pocket estimation, even if your telephone number is currently listed on any state, federal, local or corporate Do Not Call list.

b. Your Consent to be contacted through the use of automatic telephone dialing systems and artificial or pre-recorded messages is not required in order to purchase any property, goods, or services. If you would like to speak with our Benefits Investigation team, you can reach them at **+1 888.FULGENT (+1 888.385.4368), opt 3**.

SPECIMEN INFORMATION

SAMPLE TYPE

◯ Blood ◯ Buccal/Saliva ◯ Other: _____

◯ Extracted DNA & DNA Source (Blood, Buccal, Tissue, Fibroblast): _____

SAMPLE DRAW DATE (MM/DD/YYYY)*

Specimen Labeling Instructions

1. **Label each specimen tube with:**
   - Patient's full name
   - Date of birth
   - Collection date

   Specimen requirements and shipping guidelines are available at: **www.fulgentoncology.com/resources**
2. **Ship specimen with completed TRF**

Contact **info@fulgentoncology.com** for sample kits.

SELECT TEST PANEL

Full gene sequencing is not performed, only targeted alleles.

For the most updated gene list, information, and limitations on our products and services, please visit **FulgentOncology.com.**

◯ **Comprehensive PGx Panel** (FT-TP01241) **- 49 Genes**
The Comprehensive panel includes all the genes and panels listed below.

◯ **Focus PGx Panel** (FT-TP01260) **- 24 Genes**
The Focus panel includes 24 genes from the Comprehensive panel.

◯ **Oncology PGx Panel** (FT-TP01905) **- 15 Genes**
The Oncology panel includes 15 genes from the Comprehensive panel.

◯ **Custom PGx Panel** (FT-TP01690) Select any gene(s) from the 49 included in the Comprehensive panel.

☐ *ABCB1*	☐ *ATM*	☐ *CYP2B6*	☐ *CYP2D6*	☐ *DRD2*	☐ *GGCX*	☐ *HTR1A*	☐ *KIF6*	☐ *NUDT15*	☐ *UGT1A1*
☐ *ABCG2*	☐ *BCHE*	☐ *CYP2C18 (CYP2C Cluster rs12777823)*	☐ *CYP3A4*	☐ *ERCC1*	☐ *GRIK4*	☐ *HTR2A*	☐ *MT-RNR1*	☐ *OPRM1*	☐ *UGT1A4*
☐ *ACE*	☐ *CACNA1S*	☐ *CYP2C19*	☐ *CYP3A5*	☐ *F2*	☐ *GSTP1*	☐ *HTR2C*	☐ *MTHFR*	☐ *RYR1*	☐ *VKORC1*
☐ *ANKK1*	☐ *CES1*	☐ *CYP2C8*	☐ *CYP4F2*	☐ *F5*	☐ *HLA-A*	☐ *IFNL4*	☐ *NAT2*	☐ *SLCO1B1*	☐ *XRCC1*
☐ *APOE*	☐ *COMT*	☐ *CYP2C9*	☐ *DPYD*	☐ *G6PD*	☐ *HLA-B*	☐ *ITPA*	☐ *NQO1*	☐ *TPMT*	

 CLIA 05D2043189 | D# TRF-ONC-PGx-V2-072025

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Highlighted fields are required information*

BILLING OPTIONS

Please select a billing option and complete the relevant fields below: ○ Insurance ○ Institution ○ Self-Pay

By signing above, the patient or payor authorizes Fulgent and its entities to contact them directly (including via text), and authorizes Fulgent and its entities to release medical information concerning the test to the assigned insurance company.

INSURANCE/BILLING INFORMATION

Please attach front and back of all insurance cards, ABN, medical criteria form

ICD-10 VALID CODE*	REFERRAL/PRIOR AUTH	FULGENT BENEFITS ID #

PRIMARY INSURANCE ID	INSURANCE NAME	STATE	GROUP	INSURANCE PHONE #
INSURANCE PLAN	NAME OF INSURED		RELATION TO PATIENT	DATE OF BIRTH (MM/DD/YYYY)
SECONDARY INSURANCE ID	INSURANCE NAME	STATE	GROUP	INSURANCE PHONE #
INSURANCE PLAN	NAME OF INSURED		RELATION TO PATIENT	DATE OF BIRTH (MM/DD/YYYY)

INSTITUTIONAL BILLING

○ Use institution information above for billing
○ Use information below for billing

INSTITUTION/PRACTICE NAME	ATTENTION TO
ADDRESS	

CITY	STATE	POSTAL CODE	COUNTRY
PHONE	EMAIL		

SELF-PAY

○ Use patient information above for billing
○ Use information below for billing

By signing above, the patient or payor authorizes Fulgent and its entities to contact them directly, and use the provided billing instructions to bill the indicated method.

PAYOR LAST NAME	PAYOR FIRST NAME
ADDRESS	

CITY	STATE	POSTAL CODE	COUNTRY
PHONE	EMAIL		

