ARIEL
PRECISION MEDICINE

FAX TO: (844) 692-7435

Ariel Precision Medicine
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PancreasDx Test Requisition Form

The 13-gene panel represents next-generation sequencing and deletion/duplication analysis of *PRSS1-2, PRSS3, CFTR, SPINK1, CASR, CTRC, CEL, UBR1, SDBS, CPA1*, and *GGT* and sequencing of two regions of interest near *CLDN2* and a region within *SLC26A9*.

Please select if you would like either of the following panels to be included in the PancreasDx analysis:

☐ **ArielDx PGx:** A targeted 10-gene pharmacogenomics panel for medications used to treat pain: *CYP2B6, CYP2D6, CYP2C9, CYP2C19, CYP3A4, CYP3A5, OPRM1, ABCB1, HTR2A* and *COMT*.

☐ **ArielDx Lipids:** A targeted 6-gene panel for variants associated with abnormal lipid metabolism that may increase risk of pancreatitis. Genes include: *PPARG, LPL, APOA5, APOB, FABP4,* and *APOC2*.

Patient Information

This information is used to register the patient's sample collection kit. Please ensure that this information is precise and up to date. An email address **must** be provided for each patient.

Name: _____ **DOB:** MM / DD / YYYY

Email: _____ **Phone:** ( )

Indications for Testing

Select the option that best characterizes the primary etiology. This is needed to understand the patient's condition and is required for billing. These descriptors are tied to ICD-10 codes.

Acute Pancreatitis	w/o necrosis or infection	w/ uninfected necrosis	w/ infected necrosis
Alcohol-Induced	☐	☐	☐
Biliary	☐	☐	☐
Drug-Induced	☐	☐	☐
Idiopathic	☐	☐	☐
Unspecified Acute Pancreatitis	☐	☐	☐
Other Acute Pancreatitis	☐	☐	☐

Year of initial Acute Pancreatitis attack: _____
Check here if recurrent ☐
If recurrent, frequency of attacks: _____

Chronic Pancreatitis	
Alcohol-Induced	☐
Cystic	☐
Interstitial	☐
Recurrent	☐
Relapsing	☐
Other Chronic Pancreatitis	☐

Year of diagnosis: _____
Method of diagnosis: _____

Family History

☐ No known family history
☐ Unknown / Adopted

Provide information on relevant family history, especially on pancreatitis (specify chronic or acute, if known), pancreatic cancer, cystic fibrosis or CF-related disorders, or diabetes. Please include relationship to patient and maternal vs. paternal status.

_____
_____
_____
_____

Prior Genetic Testing

☐ No prior testing
☐ Prior genes tested: _____

Attach copies of all genetic testing results.
For results, format as:
(Gene | c.XXXX | p.XXXX | Pathogenic vs VUS)

_____
_____
_____
_____

TIGAR-O Classfication (check all that apply):

Toxic/Metabolic	Idiopathic	Genetic	Auto-Immune	Rec. Acute / Severe	Obstructive
☐ Alcohol related ☐ Smoking related ☐ Hypercalcemic ☐ Hypertriglyceridemia ☐ Drug Induced (Specify):	☐ Early Onset (<35 years of age) ☐ Late Onset (>35 years of age)	☐ Hereditary pancreatitis ☐ Cystic Fibrosis / CFTR-Related Disorder ☐ Familial Pancreatitis ☐ Syndrome (*SBDS, UBR1*)	☐ Isolated ☐ IgG4-related	☐ Recurrent Acute ☐ Severe acute with necrosis	☐ Biliary ☐ Pancreas Divisum ☐ Sphincter of Oddi Dysfunction ☐ Post Traumatic ☐ Post Surgical

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Indications for Testing (cont.)

Please check all that apply.

Diabetes	w/ complications	w/o complications
Type 1	☐	☐
Type 2	☐	☐
Type 3c (Pancreatogenic)	☐	☐
Mature Onset Diabetes of the Young	☐	☐
Hyperglycemia	☐	☐

Pancreatic Exocrine Insuffiency	
Pancreatic Exocrine Insuffiency	☐
Chronic Diarrhea	☐
Magnesium Deficiency	☐
Malabsorption	☐
Steatorrhea	☐
Vitamin Deficiency	☐
Zinc Deficiency	☐

Cystic Fibrosis/CFTR Disorder	
CF w/ Acute Pneumothorax	☐
CF w/ Hemoptysis	☐
CF w/ Meconium Ileus	☐
CF w/ Pneumothorax Not Otherwise Specified	☐
CF w/ Pulmonary Manifestations	☐
CF Unspecified	☐
CF w/ Other Intestinal Manifestations	☐
CF, Screen Positive, Inconclusive Diagnosis	☐
CFTR-related Acquired Chronic Bronchiectasis	☐
CFTR-related CBAVD	☐
CFTR-related Recurrent Pancreatitis	☐
CRMS Metabolic Disorder Unspecified	☐

Additional Clinical Data

Please attach or detail below any additional clinical information that supports this patient's analysis, such as any complications of current conditions, surgical or endoscopic history, or previous treatments.

Current Medications

Please detail the drug, route of admission, and dose of each currently prescribed medication.

Genetic Counseling Opt-Out

Ariel Precision Medicine offers pre-test genetic counseling to our patients. Genetic counseling is **strongly** recommended. All Ariel patients will be provided this service. By checking this box, you are choosing to opt-out of genetic counseling services provided by Ariel Precision Medicine.

☐ Initials: _____

Referring Physician

Physician Name (print): _____ Phone: (_____) _____

Address: _____ Fax: (_____) _____

Address (cont'd): _____

Email: _____

Genetic Counselor/Lab Contact Name: _____ Phone: (_____) _____

Email: _____ Fax: (_____) _____

Medical Necessity & Signature

By checking this box, I affirm the undersigned person (or representative thereof) ensures he/she is a licensed medical professional authorized to order genetic testing and confirm the patient has given appropriate consent. I confirm that testing is medically necessary and that test results may impact medical management for the patient. Furthermore, all information on this order form is true to the best of my knowledge.

I have attached a Letter of Medical Necessity (LMN) and/or other documentation for insurance billing purposes.
I agree to allow Ariel Precision Medicine to transfer this information, and any attached information, from this requisition for a LMN using the ordering physician's name as the signature for insurance billing.

Name: _____ Signature: _____ Date: _____

Title: _____ Degree: _____ NPI #: _____

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