

## Test Request Form

## Patient Information (required)

Date Collected: \_\_\_\_\_ Time: \_\_\_\_\_ AM PM

Date Separated: \_\_\_\_\_ Time: \_\_\_\_\_ AM PM

Patient Name: Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Patient Resp. Party Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Sex:  M  F DOB \_\_\_\_\_ SSN \_\_\_\_\_

Patient ID or Medical Record # \_\_\_\_\_

Reference or Order # \_\_\_\_\_

## Current Clinical Information

Diagnosis Code (REQUIRED): \_\_\_\_ 042 \_\_\_\_ v08 \_\_\_\_ 079.99

Most Recent HIV Viral Load: \_\_\_\_\_ copies/mL Date Collected: \_\_\_\_\_

Most recent CD4 count: \_\_\_\_\_ cells/mm<sup>3</sup> Date Collected: \_\_\_\_\_

## Physician Information (required)

Referring Physician: Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Physician or Contact Phone # \_\_\_\_\_

ID/License # \_\_\_\_\_

Referring Physician Provider #/NPI # \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date: \_\_\_\_\_

Fax Additional Copy to ATTN \_\_\_\_\_ Fax # \_\_\_\_\_

## Billing Information (required)

Check one box for billing type and fill out all accompanying information. Attach a copy of the front and back of insurance card(s).

 Bill Client Bill Medicare: Patient Medicare #: \_\_\_\_\_ HMO  ADAP  PPO  Medical Group IPA  Medicaid

Insured ID and or SSN \_\_\_\_\_

Insurance Company Health Plan Name and Address \_\_\_\_\_

Insurance Phone # \_\_\_\_\_

Medical Group IPA Name and Address (if applicable) \_\_\_\_\_

Relationship to Insured:  Self  Spouse  Dependent  Legal Partner

## HIV Drug Resistance Assays

**PhenoSENSE GT™** REPLICATION CAPACITY COMBINATION HIV DRUG RESISTANCE ASSAY Phenotype + genotype sequence analysis with phenotypic interpretation

Viral load must be ≥500 copies/mL and volume ≥3 mL

**PHENOSENSE™** REPLICATION CAPACITY HIV DRUG RESISTANCE ASSAY Phenotype

Viral load must be ≥500 copies/mL and volume ≥3 mL

**GeneSeq™** HIV DRUG RESISTANCE ASSAY Genotype sequence analysis with phenotypic interpretation

Viral load must be ≥500 copies/mL and volume ≥3 mL

**PhenoSENSE ENTRY™** HIV DRUG RESISTANCE ASSAY Entry inhibitor assay

Viral load must be ≥1,000 copies/mL and volume ≥3 mL

## HIV Co-receptor Tropism Assay

**trofile™** CO-RECEPTOR TROPISM ASSAY

Viral load must be ≥1,000 copies/mL and volume ≥3 mL

## Reasons for Ordering HIV Drug Resistance Test (Required for Medi-Cal)

Check all that are applicable:

## Phenotype and Genotype Test Criteria

Recipients with treatment failure following a combination of highly active antiretroviral therapy (HAART), which is defined as:

- Virologic: failure to achieve a viral load of less than 400 copies/mL at 24 weeks, or more than 50 copies/mL after 48 weeks, or a repeat viral load of more than 400 copies/mL after prior suppression of viremia to less than 400 copies/mL
- Immunologic: failure to increase CD4 count by 50 cells/mm<sup>3</sup> over baseline during the first year of treatment
- Clinical: HIV-related disease progression after at least 3 months of HAART

## Other Patient Types

- Treatment-naïve patients with acute or chronic HIV infection
- Pregnant women with HIV infection prior to initiation of therapy or for those entering pregnancy with detectable HIV ribonucleic acid levels

Forward top copy to Monogram with specimen—retain back copy for your records. For reimbursement assistance call the Gateway Line: (877) 436-6243.

The client providing this billing information to Monogram for third-party reimbursement warrants that it has complied with all federal and state laws and regulations for which client has a duty to bill directly.

All Monogram HIV Assays are intended for use only in patients with a confirmed diagnosis of HIV-1 infection. These assays are not intended to be used for diagnosis of HIV infection.

This patient is documented HIV-1 infected unless otherwise indicated.

Other: \_\_\_\_\_

Specimen Type: Plasma unless otherwise indicated.

Other: \_\_\_\_\_