MEDICAL NECESSITY DOCUMENTATION FORM

customerservice@prescientlabservices.com

www.prescientlabservices.com

INSTRUCTIONS

1. Please PRINT CLEARLY when providing required information to ensure proper processing.
2. Provide this form along with the matching DNA Test Request Form (FM-80009) for the patient in question.

PATIENT INFORMATION *(required)*

LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH

TEST RATIONALE *(required)*

Please check the appropriate boxes below and provide details where requested.

□ Patient's condition appears difficult to test as evidenced by therapeutic failure.
(PLEASE INSERT MEDICAL NOTE IN SPACE PROVIDED)

□ Patient has demonstrated sensitivity or lack of symptom relief with recommended medication dosage.
(PLEASE INSERT MEDICAL NOTE IN SPACE PROVIDED)

□ Patient is on multiple medications for his/her condition which increases the risk for adverse drug reactions.
(PLEASE INSERT MEDICAL NOTE IN SPACE PROVIDED)

□ Patient has been noncompliant with the medication treatment regimen due to adverse drug reactions
(PLEASE INSERT MEDICAL NOTE IN SPACE PROVIDED)

□ Patient has a history of medication sensitivity and/or adverse drug reactions.
(PLEASE INSERT MEDICAL NOTE IN SPACE PROVIDED)

□ Patient is suspected of abusing and/or diverting with current medication(s).
(PLEASE INSERT MEDICAL NOTE IN SPACE PROVIDED)

□ Initial onset of condition in patient with no pharmacological treatment history for condition.
(PLEASE INSERT MEDICAL NOTE IN SPACE PROVIDED)

□ Other diagnostic or medical reason not noted above.
(PLEASE EXPLAIN IN SPACE PROVIDED)

TEST APPLICATION *(required)*

Please check the appropriate boxes below.

□ Avoidance of specific medications to decrease the risk of side effects that could lead to non-compliance or treatment discontinuation by the patient.

□ Changes in dosing required to decrease side effects the patient is currently experiencing with the present drug regimen.

□ Avoidance of specific medications to minimize or eliminate the risk of serious adverse events known to occur with certain drugs or classes of drugs currently used to treat the patient's condition.

□ Changes in dosing required to reduce the risk of an adverse event(s) occurring or recurring with the medication(s) selected to treat the patient.

□ Selection of specific medications to increase the likelihood of achieving a favorable therapeutic response or treatment target.

□ Changes in dosing required to optimize therapeutic response or reach a treatment target on current medication(s).

□ Avoidance of drug interactions resulting from the concomitant use of other prescription medication(s).

□ Avoidance of metabolic interactions resulting from the concomitant use of over-the-counter or herbal medication(s).

PHYSICIAN CONSENT

Please check the appropriate boxes below; and attach to the patient's "DNA Test Request Form" (FM-80009).

STATEMENT OF MEDICAL NECESSITY

□ I certify that according to my professional experience and the patient's clinical history, these tests are absolutely medically necessary for the drug treatment of this individual. I do not use these tests for screening purposes. The tests are ordered only for my patients that warrant them, who are carefully selected from my overall practice.

STATEMENT OF IMPACT ON CLINICAL DECISION AND PATIENT MANAGEMENT

□ I certify that the information provided by these tests will be carefully reviewed by me and used in my medical decision making. I will implement a therapeutic strategy consistent with the patient's genetic profile and the overall clinical condition. I will document the medical actions that resulted from the tests in the patient health record.

PHYSICIAN NAME *(please print)*	PHYSICIAN SIGNATURE	DATE