## GENETIC TESTING PRESCRIBER ORDER FORM

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|---|---|---|---|---|
| **Patient Name:** | | **DOB:** | | |
| **Address:** | | | | |
| **Phone:** | **Height:** | ☐ inches ☐ cm | **Weight:** | ☐ lbs ☐ kg |

**Clinical Information**

| | |
|---|---|
| **Primary Diagnosis Description:** | **ICD-10 Code:** |

**Prescription**

**Decode DEB Sponsored Testing Program through PreventionGenetics. Test Code: 1578727**
Genes: CD151, CDSN, CHST8, COL17A1, COL7A1, CSTA, DSG1, DSP, DST, EXPH5, FERMT1, ITGA3, ITGA6, ITGB4, JUP, KLHL24, KRT1, KRT10, KRT14, KRT5, LAMA3, LAMB3, LAMC2, PKP1, PLEC, SERPINB8, TGM5
*Separate test requisition necessary for ordering.*

**Nursing Orders**

Skilled nurse to make one-time home visit for testing completion.
Genetic testing kit supplied by PreventionGenetics to be administered per package instructions and returned same day via mailing instructions.

*I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's results and treatment.*

**Prescriber Signature:** **Date:**

**Prescriber Information**

| | | | |
|---|---|---|---|
| **Prescriber Name:** | | **Phone:** | **Fax:** |
| **Address:** | | **NPI:** | |
| **City, State:** | **Zip:** | **Office Contact:** | |

**Fax completed form and PreventionGenetics order form: (800) 491-9561 or eFax-VyjuvekReferral@optioncare.com**



 