GENETIC TESTING PRESCRIBER ORDER FORM

Patient Name:		**DOB:**		**Gender:**
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.
If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

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 Prevention Genetics order form: (800) 491-9561 or eFax-VyjuvekReferral@optioncare.com

