Please tear at perforation

Commercial Insurance Test Requisition (January 2010)

***Indicates required information**

Medicare Patients – Please use the Athena Diagnostics Medicare Test Requisition Form. For a copy, please call Client Services or visit our website AthenaDiagnostics.com/medicare.

Medicaid/Patients Requesting Financial Assistance – Patients who meet certain income guidelines may qualify for a discount off the price of testing. Please complete the patient identification information and Athena will contact the patient directly to initiate the application process and collect pre-payment.

PATIENT

Commercially Insured Patient Information

Complete this requisition for all patients with commercial insurance.[1] Patients with a commercial insurance plan for which Athena is a contracted provider are subject to any co-insurance and deductible of their plan. Patients with a commercial insurance plan for which Athena is not a contracted provider but who have diagnostic testing (including genetic testing where applicable) as a defined benefit on their insurance plan may, in certain States[2], participate in Athena's Patient Protection Plan, which limits their financial exposure to 20% of the price of the test as long as it is paid before Athena bills the insurance. Athena will bill the patient's insurance for the total price of the test and work on his or her behalf to file all appropriate justifications and/or appeals to maximize the amount paid by the insurance when applicable. Upon receipt of the patient specimen, Athena will contact the patient to gather any missing insurance information, explain the Patient Protection Plan, and obtain the 20% payment mentioned above. If the patient does not choose to participate in the Patient Protection Plan, he or she may be balance billed after billing the insurance and may be responsible for the entire price of the test.

1. Commercial insurance does not include certain Medicare, Medicare HMO, Medicare PPO, Medicaid, or Tricare/Champus, programs for which there is a specific government-mandated billing process. Patients should verify coverage with their individual provider prior to testing. 2. Due to State laws, the Patient Protection Plan is not available in all States.

Patient Identification

Patient Name* _____ (First) _____ (Last)

Patient ID # (if available) _____

S.S. # _____ Sex: ☐ M ☐ F ☐ Unknown

DOB* _____ Age* _____

Mailing Address* _____

_____

City* _____ State* _____ Zip* _____

Phone #1* _____ ☐ Day ☐ Eve ☐ Cell

Phone #2* _____ ☐ Day ☐ Eve ☐ Cell

Appeal Authorization: In the event of an underpayment or denial by my insurance carrier, I hereby authorize Athena Diagnostics or their designee, to appeal my health plan on **my behalf**[3] to provide the actions and information necessary to overturn the denial or receive reimbursement for the underpaid claim. This authorization shall remain valid until the charges for the orders on this form are paid in full.

Authorization to Release Information and Pay Benefits: I authorize Athena Diagnostics to provide my insurance carrier all information, including test results, concerning my laboratory test(s). I understand that if I choose not to participate in the Patient Protection Plan[2] I may be responsible for all charges not covered by my insurance carrier within sixty (60) days of claim submission. I authorize and direct that benefits under this claim be paid directly to Athena Diagnostics, and I agree to remit to Athena within thirty (30) days any payment for these services made directly to me. I acknowledge that the charges for the test(s) ordered by my physician will be withdrawn in the event of cancellation only if such cancellation is executed by the ordering physician and a copy of the written confirmation evidencing this action is provided to Athena prior to the issuance of the test result.

2. Due to State laws, the Patient Protection Plan is not available in all States. 3. Athena Diagnostics and or designee may perform this appeal on my behalf, but is not obligated to do so.

STOP Signature Required Here

_____

Patient Signature*

Date _____

Patient Insurance Information

Please provide a photocopy of the front and back of the insurance card.

Name of Insured* _____ (First) _____ (Last)

Relationship to Patient:* ☐ Self ☐ Parent ☐ Spouse ☐ Other

Member ID #* _____

Group ID #* _____

Insurance Co. Name* _____

Address* _____

City* _____ State* _____ Zip* _____

Phone _____

PHYSICIAN

Physician/Laboratory Contact Information

Contact Name _____ (First) _____ (Last)

Phone _____ Fax _____

Email _____

Tests Ordered*

Important: Write in the test code and test name (see list on reverse).

Code _____ Name _____

Code _____ Name _____

ICD-9 Code (Required): _____

For BAbs/NAbs Testing, please provide IFN-ß start date: _____

Indications for Testing (Check One)*

☐ Diagnostic (symptomatic) ☐ Clinical Study ☐ Prenatal
☐ Predictive (asymptomatic) ☐ Carrier ☐ Other Research

Testing Authorization and ICD-9 Code: I warrant that this test is either: 1) for the purpose of diagnosing or detecting an existing disease, illness, impairment, symptom or disorder, or 2) that if it is not for such purpose, I have obtained the appropriate prior written consent. This written consent was signed by the person who is the subject of the test (or if that person lacks capacity to consent, signed by the person authorized to consent for that person), and includes: a) a statement of the purpose and description of the test; b) a statement that prior to signing the consent form, the consenting person discussed with the medical practitioner ordering the test the reliability of positive or negative test results and the level of certainty that a positive test result for that disease or condition serves as a predictor of such disease; c) a statement that the consenting person was informed about the availability and importance of further testing, physician consultation and genetic counseling, and provided with written information identifying a genetic counselor or medical geneticist from whom the consenting person might obtain such counseling; d) a general description of each specific disease or condition tested for; and e) the person or persons to whom the test results may be disclosed as indicated above.

_____

Medical Practitioner Signature*

Required Physician Information

NPI #* _____ UPIN #* _____

Name* _____ (First) _____ (Last)

Address _____

City _____ State _____ Zip _____

Phone* _____ Fax _____

Email* _____

Additional Authorized Result Report Recipient

Name _____ (First) _____ (Last)

UPIN # or CLIA # _____

Address _____ (P.O. Box not acceptable)

City _____ State _____ Zip _____

Phone _____ Fax _____

Email _____

Type of Specimen ☐ Whole Blood ☐ Serum ☐ CSF ☐ Buccal Swabs ☐ Muscle ☐ Plasma ☐ CVS: Direct ☐ CVS: Cultured
☐ Amniotic Fluid: Direct ☐ Amniotic Fluid: Cultured Date Collected* _____

For Athena's Specimen Collection Service*, Please Fax this Test Requisition to Access Athena™ at 866-223-1247

*Specimen collection service will work with the patient to obtain phlebotomy services through either a home draw or other laboratory.

Athena Diagnostics Testing Services (January 2010)

Not all available tests are listed here. Please see our catalog or website for complete offering, as well as CPT codes for each test.

Important: Please be sure to write in test code and test name in the Tests Ordered section on front.

Test Code		Preferred Specimen	Minimum Volume	Tube Type
Dementia				
☐ **178**	**ADmark® Alzheimer's Evaluation*** (ApoE, Phospho-Tau, Total-Tau, Aß42) (Symptomatic for Dementia)	C, B	2ml, 10ml	P, L
☐ **179**	**ADmark® Early-Onset Alzheimer's Evaluation*** (PS-1, APP Sequencing/Duplication, PS-2)	B	10ml	L
☐ 109	ADmark® ApoE Genotype Analysis & Interpretation* (Symptomatic for Dementia)	B	10ml	L
☐ 177	ADmark® Phospho-Tau/Total-Tau/Aß42 CSF Analysis & Interpretation* (Symptomatic) (must arrive in Polypropylene CSF transfer tube)	C	2ml	P
☐ 167	ADmark® PS-1 DNA Sequencing Test*	B	10ml	L
☐ 168	ADmark® APP DNA Sequencing/Duplication Test*	B	10ml	L
☐ 169	ADmark® PS-2 DNA Sequencing Test*	B	10ml	L
Developmental Disorders				
☐ **743**	**Autism Spectrum Disorders Evaluation*** (SHANK3, CNTNAP2)	B	10ml	L
☐ 741	CNTNAP2 DNA Sequencing Test*	B	10ml	L
☐ 742	SHANK3 DNA Sequencing Test*	B	10ml	L
☐ 104	Fragile X (FMR1) DNA Test*	B	20ml	L
☐ **153**	**Complete Rett Syndrome Evaluation*** (MECP2 Sequencing, MECP2 Duplication/Deletion)	B	10ml	L
☐ 142	Rett Syndrome (MECP2) DNA Sequencing Test	B	10ml	L
☐ 148	Rett Syndrome (MECP2) Duplication/Deletion Analysis*	B	10ml	L
☐ 149	CDKL5 DNA Sequencing Test*	B	10ml	L
☐ 141	ARX DNA Sequencing Test*	B	10ml	L
☐ 706	Chromosome Analysis with Fragile X DNA Test*	B	20ml, 20ml	L, G
☐ 707	Chromosome Analysis – High Resolution*	B	30ml	G
☐ 630	Norrie Disease DNA Test†	B	20ml	L
☐ **702**	**44K Chromosomal Microarray Analysis*** Adult:	B	10ml, 10ml	L, G
☐ **703**	**105K Chromosomal Microarray Analysis*** Child:	B	8ml, 8ml	L, G
	Infant:	B	4ml, 4ml	L, G

Indication for Study (MUST check one or more below):

☐ Developmental Delay/Mental Retardation: ☐ Mild ☐ Moderate ☐ Severe
☐ Autistic Spectrum ☐ Failure to Thrive
☐ Multiple Congenital Anomalies ☐ Infertility
☐ Trisomy 13 ☐ Dysphormic Features
☐ Fetal Demise ☐ Trisomy 18
☐ Klinefelter or Turner Syndrome ☐ Seizures
☐ Trisomy 21 ☐ Multiple Miscarriages (#_____)
☐ Testicular Failure ☐ Ambiguous Genitalia
☐ TBD ☐ Other:_____
☐ FMX: _____

Previous Cytogenetic Results (if applicable): _____
Family Members Studied at Athena: _____
_____ Proband Accession #: _____

Test Code		Preferred Specimen	Minimum Volume	Tube Type
Epilepsy				
☐ **556**	**Complete Tuberous Sclerosis Evaluation*** (TSC1 Seq., TSC1 Del., TSC2 Seq., TSC2 Del.)	B	20ml	L
☐ 521	TSC1 DNA Sequencing Test*	B	10ml	L
☐ 508	TSC1 DNA Deletion Test*	B	10ml	L
☐ 522	TSC2 DNA Sequencing Test*	B	10ml	L
☐ 524	TSC2 DNA Deletion Test*	B	10ml	L
☐ 523	TSC Familial Mutation Evaluation* Proband Accession #_____ Relationship _____	B	10ml	L
☐ 549	Alexander Disease (GFAP) DNA Sequencing Test	B	10ml	L
☐ 441	SLC2A1 (GLUT1-DS) DNA Sequencing Test* *Avail 2/28/10*	B	10ml	L
☐ **418**	**Myoclonus Epilepsy Evaluation*** (EPM1, EPM2A, EPM2B, MERRF, EFHC1)	B	20ml	L
☐ **573**	**SCN1A Complete Evaluation*** (SCN1A Sequencing, SCN1A Deletion)	B	10ml	L
☐ **548**	**Febrile Seizures Evaluation*** (SCN1A Seq., SCN1A Del., SCN1B Seq., GABRG2 Seq.)	B	10ml	L
☐ **507**	**Female Febrile Seizures Evaluation*** (PCDH19 Seq., SCN1A Seq., SCN1A Del., SCN1B Seq., GABRG2 Seq.)	B	10ml	L
☐ 509	PCDH19 (EFMR) DNA Sequencing Test*	B	10ml	L
☐ 535	SCN1A DNA Sequencing Test*			
☐ 537	SCN1A Deletion Test*			
☐ 538	SCN1B DNA Sequencing Test*			
☐ 544	GABRG2 DNA Sequencing Test			
☐ **415**	**Lafora Disease Evaluation*** (EPM2A, EPM2B)	B	20ml	L
☐ 411	EPM2A DNA Test*	B	10ml	L
☐ 412	EPM2B DNA Test*			
☐ 410	EPM1 (Unverricht-Lundborg) DNA Test*			
☐ 545	KCNQ2 (BFNC) DNA Sequencing Test*			
☐ 417	EFHC1 (JME) DNA Sequencing Test*			
☐ 572	KCNJ10 DNA Sequencing Test*			
☐ **547**	**ADNFLE Evaluation*** (CHRNA4, CHRNB2)	B	10ml	L
☐ 546	CHRNA4 DNA Sequencing Test*	B	10ml	L
NOTE: Pediatric minimum for all Epilepsy tests is 2ml.				
Family Testing				
☐ **185**	**Familial DNA Sequence Evaluation*** This test detects previously identified sequence variants in at-risk family members. This test cannot be applied to the TTR gene. For Familial TSC mutations, please order Test Code 523. Proband Accession #_____ Relationship _____	B	10ml	L
Hearing Loss				
☐ **329**	**Connexin Related Deafness Evaluation*** (Connexin 26, Connexin 30)	B	10ml	L
☐ 321	Connexin 26 DNA Sequencing Test*	B	10ml	L
☐ 319	Connexin 30 DNA Deletion Test*			
☐ 327	OtoDx™ Aminoglycoside Hypersensitivity Test*	B	20ml	L
Migraine				
☐ **190**	**Hemiplegic Migraine Evaluation*** (CACNA1A, ATP1A2, SCN1A)	B	10ml	L
☐ 187	FHM1 DNA Test (CACNA1A)*	B	10ml	L
☐ 188	FHM2 DNA Test (ATP1A2)*			
☐ 189	FHM3 DNA Test (SCN1A)*			
Motor Neuron Diseases				
☐ **650**	**Complete Hereditary Spastic Paraplegia Evaluation*** (Includes all individual HSP DNA tests, see below.)	B	10ml	L
☐ **651**	**Autosomal Dominant Hereditary Spastic Paraplegia Evaluation*** (SPG3A, SPG4, SPG4 Del., SPG6, SPG8, SPG17, SPG31)	B	10ml	L
☐ **652**	**Autosomal Recessive Hereditary Spastic Paraplegia Evaluation*** (SPG7, SPG11)	B	10ml	L
Individual HSP DNA Tests:		B	10ml	L
☐ 530	Spastin (SPG4)	☐ 532	NIPA1 (SPG6)*	
☐ 531	Atlastin (SPG3A)*	☐ 533	Strumpellin (SPG8)*	
☐ 529	REEP1 (SPG31)*	☐ 632	Paraplegin (SPG7)*	
☐ 534	Spastin (SPG4 Del.)*	☐ 633	Spatacsin (SPG11)*	
		☐ 631	BSCL2 (SPG17)*	
☐ **215**	**Complete SMA Evaluation (Reflexive)** This is a reflexive test. Tests will be run in succession until either a positive result is detected or the profile is completed. Testing is performed in this order: 1. SMN1 Del.; 2. SMN1 Seq.; 3. IGHMBP2 (SMARD), XLSMA	B	6-10ml	L
☐ **214**	**SMA Plus (Reflexive)** This is a reflexive test. Tests will be run in succession until either a positive result is detected or the profile is completed. Testing is performed in this order: 1. SMN1 Deletion; 2. SMN1 Sequencing	B	6-10ml	L
☐ **111C**	**Spinal Muscular Atrophy – Carrier***	B	10ml	L
☐ **111D**	**Spinal Muscular Atrophy – Diagnostic*** (Including SMN2 Copy Number)	B	10ml	L
☐ 211	Spinal Muscular Atrophy – SMN1 DNA Sequencing Test	B	6-10ml	L
☐ 212	Spinal Muscular Atrophy with Respiratory Distress (SMARD) IGHMBP2 DNA Sequencing Test	B	6-10ml	L
☐ 213	X-Linked Spinal Muscular Atrophy (XLSMA) UBE1 DNA Sequencing Test (Exon 15 only)	B	6-10ml	L
☐ 117	Kennedy Disease (SBMA) DNA Test*	B	10ml	L
☐ **723**	**Complete ALS Evaluation*** (SOD1, FUS, TARDBP, ANG, FIG4)	B	20ml	L

Important: Please be sure to write in test code and test name in the Tests Ordered section on front.

athena diagnostics

Test Code		Preferred Specimen	Minimum Volume	Tube Type
☐ 620	SOD1 DNA Sequencing Test*	B	20ml	L
☐ 619	FUS DNA Sequencing Test*	B	10ml	L
☐ 621	TARDBP DNA Sequencing Test*	B	10ml	L
☐ 622	ANG DNA Sequencing Test*	B	10ml	L
Movement Disorders				
☐ **690/695**	**Complete Ataxia Evaluation** *695 Avail 2/28/10* (Includes all individual Ataxia genes, see below.)	B	20ml	L
☐ **680/694**	**Autosomal Dominant Ataxia Evaluation** (SCA1,2,3,5,6,7,8,10,13,14,17, DRPLA) *694 Avail 2/28/10*	B	20ml	L
☐ **693**	**Autosomal Recessive Ataxia Evaluation*** (APTX, SETX, SIL1, POLG1, TTPA, FRDA sequencing, FRDA expansion) *Avail 2/28/10*	B	20ml	L
Individual Ataxia DNA Tests:		B	10ml	L
☐ 371	SCA1	☐ 372/672	SCA2 *672 Avail 2/28/10*	
☐ 105	SCA3	☐ 389/675	SCA5 *675 Avail 2/28/10*	
☐ 373	SCA6*	☐ 374/677	SCA7 *677 Avail 2/28/10*	
☐ 384	SCA8	☐ 387	SCA10	
☐ 284	SCA13	☐ 593	SCA14	
☐ 388	SCA17	☐ 493	APTX	
☐ 401	DRPLA	☐ 383	POLG1 (MIRAS)	
☐ 594	SETX	☐ 282	SIL1 (MSS)	
☐ 283	TTPA (AVED)	☐ 348	FRDA DNA Seq. *Avail 2/28/10*	
☐ 119	FRDA Expansion			
☐ **349**	**Friedreich's Ataxia Profile** *Avail 2/28/10* (FRDA Sequencing, FRDA Expansion)	B	10ml	L
☐ **353**	**Complete Ataxia-Telangiectasia (ATM) Evaluation*** (ATM Sequencing, ATM Duplication/Deletion) *Avail 2/28/10*	B	10ml	L
☐ 351	Ataxia-Telangiectasia (ATM) DNA Sequencing Analysis* *Avail 2/28/10*	B	10ml	L
☐ 352	Ataxia-Telangiectasia (ATM) DNA Duplication/ Deletion Analysis* *Avail 2/28/10*	B	10ml	L
☐ **402**	**Chorea Differential Evaluation*** (DRPLA, HD)	B	20ml	L
☐ 116	Huntington's Disease DNA Test*	B	10ml	L
☐ **629**	**Complete Dopa-Responsive Dystonia (DYT5) Evaluation*** (GCH1 Sequencing, GCH1 Deletion, TH Sequencing)	B	10ml	L
☐ 637	GCH1 DNA Sequencing Test (DYT5)*	B	10ml	L
☐ 638	GCH1 Del. Analysis (DYT5)*	B	10ml	L
☐ 634	TH DNA Sequencing Test (DYT5)*	B	10ml	L
☐ 624	SGCE DNA Sequencing Test (DYT11)*	B	10ml	L
☐ 627	SGCE Del. Analysis (DYT11)*	B	10ml	L
☐ 626	Dystonia (DYT1) DNA Test*	B	20ml	L
☐ 106	FXTAS DNA Test*	B	20ml	L
☐ **555**	**Complete Parkinsonism Evaluation*** (Parkin, PINK1, LRRK2)	B	20ml	L
☐ **550**	**Autosomal Recessive Parkinsonism Evaluation*** (Parkin, PINK1)	B	20ml	L
☐ 540	Parkin DNA Test*	B	20ml	L
☐ 542	PINK1 DNA Sequencing Test*			
☐ 543	LRRK2 DNA Test			
Multiple Sclerosis				
☐ 194	BAbScreen®/NAbFeron® (IFN-ß) Antibody Test (Binding Antibody positive confirmed by NAbFeron® Test)	S	2ml	R
☐ 112	NAbFeron® (IFN-ß) Neutralizing Antibody Test	S	2ml	R
☐ 197	Tysabri® (Natalizumab) Antibody Test (must arrive on cold pack)	S	2ml	R
Neuromuscular Disorders				
☐ 482	MuSK Quantitative Titers Antibody Test	S	2ml	R
☐ 483	AChR/MuSK Reflexive Antibody Test (Now with MuSK quantitative titers levels)	S	2ml	R
☐ **506**	**Male Muscular Dystrophy Reflexive Profile** This is a reflexive test. Tests will be run in succession until either a positive result is detected or the profile is completed. Testing is performed in this order: 1. DMD Del./Dup.; 2. DMD Seq.; 3. Limb Girdle Muscular Dystrophy Evaluation.	B	20ml	L

Test Code		Preferred Specimen	Minimum Volume	Tube Type
☐ **181**	**Complete DMD Evaluation – Males***	B	20ml	L
☐ **182**	**Complete DMD Evaluation – Females***	B	20ml	L
☐ 101	Partial DMD Deletion/Duplication only – Males*	B	20ml	L
☐ 103	Partial DMD Deletion/Duplication only – Females*	B	20ml	L
☐ 183	Partial DMD DNA Sequencing Only*	B	20ml	L
☐ 100	Dystrophin Test	M	10mg	C
☐ **147**	**Complete Myotonia Evaluation*** (DM1, DM2, CLCN1, SCN4A)	B	10ml	L
☐ **207**	**Early Onset Myotonia Evaluation*** (DM1, CLCN1, SCN4A)	B	10ml	L
☐ 108	DM1 DNA Test	☐ 110	DM2 DNA Test*	B	10ml	L
☐ 128	CLCN1 DNA Test*	☐ 146	SCN4A DNA Test*			
☐ **569**	**Emery-Dreifuss Muscular Dystrophy Evaluation*** (EMD and LMNA)	B	10ml	L
☐ 567	EMD DNA Sequencing Test*	B	10ml	L
☐ **601**	**Limb Girdle Muscular Dystrophy Evaluation*** (CAPN3, CAV3, Dysferlin Sequencing, FKRP, LMNA, SGCA, B, G, D)	B	20ml	L
Individual Limb Girdle Muscular Dystrophy Tests:		B	10ml	L
☐ 562	FKRP*	☐ 563	CAPN3	
☐ 565	LMNA*	☐ 566	CAV3*	
☐ 568	Sarcoglycans (SGCA, B, G, D)*			
☐ 561	Dysferlin Blood Test* (must arrive on cold pack)	B	15ml	L
☐ 571	Dysferlin Sequencing Test*	B	10ml	L
☐ 405	FSHD DNA Test*	B	20ml	L
☐ 300	OPMD DNA Test*	B	10ml	L
☐ **500**	**Mitochondrial Enzyme Deficiency Myopathy Panel** (COX; Rotenone sensitive NADH reductase; Succinate dehydrogenase; Total protein; NADH dehydrogenase; Citrate synthase; Succinate-cytochrome c reductase)	M	100mg	C
☐ **501**	**Myoglobinuria Test Panel** (LDH, PGM, PGK, Glycogen, Ph, PhK; PFK, MAD, CPT2)	M	250mg	C
☐ **502**	**Glycogen Storage Myopathy 'A' Profile** (Glycogen, Acid and neutral maltase, Debrancher)	M	200mg	C
☐ **503**	**Glycogen Storage Myopathy 'B' Profile** (PhK, PFK)	M	200mg	C
☐ **504**	**Lipid Storage Myopathy Profile** (Carnitine free & total)	M	100mg	C
☐ **519**	**Mitochondrial Myopathy mtDNA Evaluation*** (MELAS, MERRF, NARP)	B	20ml	L
☐ **517**	**MELAS mtDNA Evaluation*** (MELAS 3243, 3271, 3252, 3256, 3291, 13513)	B	20ml	L
☐ **518**	**MERRF mtDNA Evaluation** (MERRF 8344, 8356, 8296, 8363)	B	20ml	L
☐ 516	NARP mtDNA Evaluation (NARP 8993)	B	20ml	L
☐ 514	KSS/CPEO mtDNA Profile	M	100mg	C
☐ **515**	**LHON mtDNA Profile*** (LHON 11778, 3460, 15257, 14484)	B	20ml	L
☐ **490**	**Optic Atrophy Evaluation** (OPA1)	B	20ml	L
☐ 635	Neurofibromatosis Type 2 DNA Test†	B	20ml	L
☐ **600**	**Peroxisomal Disorders Test†** (VLCFA, Phytanic acid)		Please Call	
Paraneoplastic Syndromes				
☐ **429**	**NeoComplete Paraneoplastic Profile with Recombx™** (Hu, Yo, Zic4, CV2, MaTa, Ri, CAR, LEMS, VGKC, Amphiphysin, nAChR)	S	2ml	R
☐ **431**	**NeoCerebellar Degeneration Paraneoplastic Profile with Recombx™** (Hu, Yo, Zic4, CV2, MaTa, Ri, Amphiphysin)	S	2ml	R
☐ **432**	**NeoEncephalitis Paraneoplastic Profile with Recombx™** (Hu, CV2, MaTa, VGKC, Amphiphysin)	S	2ml	R
☐ **436**	**NeoSensory Neuropathy Paraneoplastic Profile with Recombx™** (Hu, CV2, Amphiphysin)	S	2ml	R
Individual Recombx™ Antibody Tests:		S	2ml	R
☐ 118	CAR	☐ 123	CV2	☐ 120	Hu			
☐ 122	MaTa	☐ 115	Ri	☐ 125	Yo			
☐ 127	Zic4							
☐ 475	LEMS (VGCC) Antibody Test	S	2ml	R
☐ 485	VGKC Antibody Test	S	2ml	R

Test Code		Preferred Specimen	Minimum Volume	Tube Type
☐ 427	Amphiphysin Antibody Test	S	2ml	R
☐ 428	Ganglionic AChR (nAChR) Antibody Test	S	2ml	R
Peripheral Neuropathy: Autoimmune				
☐ **287**	**SensoriMotor Neuropathy Profile-Complete** (Co-GM1 Quattro®, MAG 'Dual Antigen'®, Hu, GALOP™, Sulfatide)	S	2ml	R
☐ **263**	**Sensory Neuropathy Profile-xp** (MAG 'Dual Antigen'®, Hu, GALOP™, Sulfatide)	S	2ml	R
☐ **288**	**Motor Neuropathy Profile-Complete** (Co-GM1 Quattro®, MAG 'Dual Antigen'®)	S	2ml	R
☐ **289**	**Multifocal Neuropathy Evaluation** (Co-GM1 Quattro®, PMP22 Duplication/Deletion)	S, B	2ml, 20ml	R, Y
☐ **234**	**Small Fiber Painful Axonal Neuropathy Profile** (Hu, Sulfatide, TTR)	S, B	2ml, 20ml	R, L
☐ 277	Co-GM1 Quattro® Antibody Test	S	2ml	R
☐ 145	MAG 'Dual Antigen'® Antibody Test	S	2ml	R
☐ 261	GALOP™ Antibody Test	S	2ml	R
☐ 210	Sulfatide Antibody Test	S	2ml	R
☐ 160	GQ1b Antibody Test	S	2ml	R
☐ 278	GD1a Antibody Test	S	2ml	R
Peripheral Neuropathy: Hereditary				
☐ **404**	**Complete CMT Evaluation** (Includes all individual CMT DNA tests, see below)	B	20ml	L
☐ **414**	**Dominant CMT Evaluation** (Cx32, Cx32 Del., MPZ, EGR2, NFL, PMP22, LITAF/SIMPLE, MFN2, PMP22 Duplication/Deletion, RAB7, GARS, HSPB1)	B	20ml	L
☐ **407**	**Partial CMT – Demyelinating Only** (Cx32, Cx32 Deletion, MPZ, EGR2, PMP22, PMP22 Duplication/Deletion, GDAP1, PRX, LITAF/SIMPLE, SH3TC2)	B	20ml	L
☐ **413**	**Partial CMT – Axonal Only** (Cx32, Cx32 Deletion, MPZ, NFL, GDAP1, MFN2, RAB7, GARS, HSPB1, LMNA)	B	20ml	L
☐ **409**	**Partial CMT – Recessive Only** (PRX, EGR2, GDAP1, SH3TC2, FIG4, LMNA)	B	20ml	L
☐ **243**	**Complete HNPP Evaluation** (PMP22, PMP22 Dup./Del.)	B	20ml	L
☐ **286**	**Complete Dejerine-Sottas Neuropathy Evaluation** (MPZ, EGR2, PMP22, PRX)	B	20ml	L
☐ **347**	**Chronic Demyelinative Neuropathy Profile** (MAG 'Dual Antigen'®, GD1b, PMP22 Duplication/Deletion, Cx32, Cx32 Deletion)	S, B	2ml, 20ml	R, L

Test Code		Preferred Specimen	Minimum Volume	Tube Type
☐ **245**	**Congenital Hypomyelination Evaluation** (MPZ, EGR2)	B	20ml	L
☐ **296**	**Entrapment Neuropathy Evaluation** (PMP22, PMP22 Duplication/Deletion, TTR)	B	20ml	L
☐ **235**	**Amyloidosis Evaluation** (TTR)	B	20ml	L
Individual CMT DNA Tests:		B	10ml	L
☐ 221	GDAP1 (CMT2K, 4A)			
☐ 222	LITAF/SIMPLE (CMT1C)*			
☐ 223	MFN2 (CMT2A2)			
☐ 239	Periaxin (CMT4F)			
☐ 247	PMP22 Sequencing			
☐ 248	EGR2 (CMT1D)			
☐ 249	NFL (CMT2E, 1F)			
☐ 131	PMP22 Dup./Del. (CMT1A)			
☐ 134	MPZ (CMT1B, 2I, 2J)			
☐ 226	LMNA (CMT2B1, 4C1)			
☐ 224	SH3TC2 (CMT4C)			
☐ 227	RAB7 (CMT2B)			
☐ 225	FIG4 (CMT4J)			
☐ 228	GARS (CMT2D)			
☐ 143	Cx32 Seq./Del. (CMTX)			
☐ 229	HSPB1 (CMT2F)			
Stroke/Thrombosis				
☐ **421**	**Complete CADASIL Evaluation***	B	10ml	L
☐ 090	THROMBOGENE V® Test (Factor V)*	B	10ml	L
☐ **098**	**THROMBX® Evaluation Profile I** (Factor V, ATIII function, Protein C function, Protein S function, Anticardiolipin: IgG, IgM, IgA screen)*	B, P	10ml, 4ml	L, B
☐ **099**	**THROMBX® Evaluation Profile II** (Factor V, ATIII function, Protein C antigen, Protein S antigen, Protein C/Factor VII ratio, Protein S/Factor VII ratio, Anticardiolipin: IgG, IgM, IgA screen)	B, P	10ml, 4ml	L, B
Drug Monitoring				
☐ 113	Botulinum Toxin Type A Antibody Test	S	2ml	R

*Medicare ABN required. †Test not available from Athena Diagnostics for Medicare patients.

Specimen Type		Tube Type		
C – CSF	M – Muscle Tissue	P – Polypropylene CSF Transfer Tube		
B – Blood	P – Plasma	G – Green	B – Blue	R – Red
S – Serum		L – Lavender	C – Cryovial	

Athena Diagnostics Client Service Representatives are available from 8:30 a.m. to 6:30 p.m. Eastern Time (US).

Customers in the US and Canada please call toll-free

866-AthenaDx (866-284-3623)

(Non-US customers please call 508-756-2886 or fax 508-753-5601.)

athena diagnostics®

Testing that Makes a Difference.

Four Biotech Park, 377 Plantation Street
Worcester, MA 01605 • www.AthenaDiagnostics.com

ADX144SG-1/10AK-REV21

Important: Please be sure to write in test code and test name in the Tests Ordered section on front.