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Luminex CYP 2D6, CYP 2C19;

Methodology	Amplification
Name And Description:	Polymerase Chain Reaction (PCR)
Specimen Requirements:	<b>Buccal Swabs:</b> 1 sterile buccal swabs
Clinical Info:	<p><b>CYP2D6</b> acts on 25% of all prescription drugs. 7-14% of the population has a slow acting form of this enzyme and 7% a super-fast acting form. 35 percent are carriers of a non-functional CYP2D6 allele, which especially elevates the risk of adverse drug reactions when these individuals are taking multiple drugs.</p> <p><b>CYP2C19</b> acts on 5-10% of drugs in current clinical use. About 2-6% of individuals of European origin, 15-20% of Japanese, and 10-20% of Africans have a slow acting, poor metabolizer form of this enzyme. However there is wide variability among populations. For example, the percent of Polynesians who are poor metabolizers ranges from 38-79% depending on location. CYP2C19 is an important drug metabolizing enzyme that catalyzes the biotransformation of many other clinically useful drugs including antidepressants, barbiturates, proton pump inhibitors, antimalarial and anti-tumor drugs.</p>
Days Performed:	Monday – Friday (CMCD Holidays Excluded)
Reported:	5 Days from receipt of acceptable specimen in lab
CPT Code(s):	CYP2D6 (81226); CYP2C19 (81225)

CLIA# 36D2061372

ADDRESS: 8285 Darrow Road, Ste 101 Twinsburg, OH 44087

CAP# 7541618

PHONE: 330-405-2623



Center for Molecular Cancer Diagnostics, INC.

<b>LAB USE ONLY</b>	
Received by _____	
Date Rec'd _____	Time Rec'd _____

**ACCOUNT INFORMATION**

Account No. \_\_\_\_\_ Phone No. \_\_\_\_\_

Treating Physician \_\_\_\_\_ UPIN No. \_\_\_\_\_

Requesting Physician Signature  
I certify that I intend to order the services indicated which I consider medically necessary for the diagnosis and treatment of the patient. In accordance with CMS guidelines, all laboratory orders must either be signed by the ordering physician on the requisition or be documented and signed in the patient's medical record.

Duplicate Report To: \_\_\_\_\_

Address: \_\_\_\_\_

Fax: \_\_\_\_\_

**PATIENT INFORMATION**

Last Name \_\_\_\_\_ MI \_\_\_\_\_

First Name \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone No. \_\_\_\_\_

Sex:  (M)  (F)      **DOB** \_\_\_\_\_

Patient ID No. \_\_\_\_\_      **Chart No.** \_\_\_\_\_

**BILLING INFORMATION**

Bill to: Select One

Medicare    Medicaid    Patient's Insurance    Physician Bill    Self Pay    Other Insurance

PLEASE ATTACH COPY OF FRONT AND BACK OF INSURANCE CARD

Patient is:  Subscriber    Spouse    Other Dependent

Primary Insurance Name: \_\_\_\_\_ Policy No. \_\_\_\_\_

Group No. \_\_\_\_\_ Insured's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Secondary Insurance Name: \_\_\_\_\_ Policy No. \_\_\_\_\_

Group No. \_\_\_\_\_ Insured's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Specimen Information:** Date of Collection: \_\_\_\_\_ Time of Collection: \_\_\_\_\_

Type:  Buccal Swab

**DRUG METABOLISM - CONDITIONS AND CLASSES**  
(Please check box next to tests you wish performed. Refer to Conditions and Pharmaceutical List for Guidance)

<input type="checkbox"/> <b>Cardiology (ALL)</b> <input type="checkbox"/> Antiarrhythmics <input type="checkbox"/> Antihypertensives <input type="checkbox"/> Platelet Aggregation Inhibitors	<input type="checkbox"/> <b>Pain Management (ALL)</b> <input type="checkbox"/> Antidepressants <input type="checkbox"/> Antiepileptics <input type="checkbox"/> Benzodiazepines <input type="checkbox"/> Muscle Relaxants <input type="checkbox"/> Opioids	<input type="checkbox"/> <b>Mental Health (ALL)</b> <input type="checkbox"/> Antidepressants <input type="checkbox"/> Antiepileptics <input type="checkbox"/> Antipsychotics	<input type="checkbox"/> <b>Other (ALL)</b> <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Proton Pump Inhibitors
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**PATIENT REQUEST**

I authorize any holder of medical or other information about me to release to the Social Security Administration, its intermediates, Blue Shield, or other carriers any information needed for this or related claims. I permit a copy of this authorization to be used in place of the original; and request payment of medical insurance benefits.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

## Drug Metabolism - Conditions and Pharmaceuticals List

	Class	Drug	Brand Example	Genes
Cardiology	Antiarrhythmics	Flecainide	Tambacor	CYP2D6
		Propafenone	Tythmol SR	CYP2D6
	Antihypertensives	Metoprolol	Lopressor, Toprol XL	CYP2D6
	Platelet Aggregation Inhibitors	Clopidogrel	Plavix	CYP2C19
Pain Management	Antidepressants	Amitriptyline	Elavil	CYP2D6
		Clomipramine	Anafranil	CYP2D6, CYP2C19
		Citalopram	Celexa	CYP2C19
				CYP2D6
		Desipramine	Norpamin	
		Doxepin	Sinequan	CYP2D6, CYP2C19
		Escitalopram	Lexapro	CYP2C19
		Imipramine	Tofranil	CYP2D6, CYP2C19
		Nortriptyline	Pamelor	CYP2D6
		Paroxetine	Paxil, Pexeva	CYP2D6
		trimipramine	surmontil	CYP2D6, CYP2C19
		Venlafaxine	Effexor	CYP2D6
	Antiepileptics	Mephenytoin	Mesantoin	CYP2C19
	Benzodiazepines	Diazepam	Valium	CYP2C19
	Muscle Relaxants	Carisoprodol	Soma	CYP2C19
	Opioids	Codeine	Tylenol #3	CYP2D6
		Hydrocodone	Lortab, Vicodin	CYP2D6
		Oxycodone	Oxycontin, Percocet	CYP2D6
		Tramadol	Ultram	CYP2D6
	Mental Health	Antidepressants	Amitriptyline	Elavil
		Citalopram	Celexa	CYP2C19
		Desipramine	Norpramin	CYP2D6
		Doxepin	Sinequan	CYP2D6, CYP2C19
		Escitalopram	Lexapro	CYP2C19
		Impramine	Tofranil	CYP2D6, CYP2C19
		Nortriptyline	Pamelor	CYP2D6
		Paroxetine	Paxil, Pexeva	CYP2D6
		Trimipramine	Surmontil	CYP2D6, CYP2C19
		Venlafaxine	Effexor	CYP2D6
		Clomipramine	Anafranil	CYP2D6, CYP2C19
Antiepileptics		Mephenytoin	Mesantoin	CYP2C19
Other		Chemotherapeutics	Tamoxifen	Nolvadex, Soltamox
	Proton Pump Inhibitors	Lansoprazole	Prevacid	CYP2C19
		Omeprazole	Prilosec	CYP2C19
		Pantoprazole	Protonix	CYP2C19