Cincinnati Children's
changing the outcome together

Test Requisition Form [Required]

Peroxisomal Biogenesis Disorder - Zellweger Spectrum Disorder
Atypical Bile Acid Test

REPORT TO

Physician Name (print): _____

Clinic/Institution Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____

Email: _____

NPI # _____

FAX NUMBER FOR RESULTS: _____

The Laboratory DOES NOT bill patients or insurance companies

This is a program supported by Mirum Pharmaceuticals, Inc.

SAMPLE/SPECIMEN INFORMATION

Sample Type: Serum (0.5 - 1 mL)

Sample Collection Date (MM/DD/YYYY): _____/_____/_____

Internal Use only:

Received date: _____

FL#: _____

FAB#: _____

SHIPPING INFORMATION

Shipment Requirements:

- **US SHIPMENTS ONLY**
- Using the prepaid shipping label provided, ship on cold pack immediately to arrive overnight, Monday-Friday. No weekend delivery.
- Label the tube with the patient's name, date of birth, and date of collection.

Ship to:

Clinical Mass Spectrometry Facility, MLC 7019
Department of Pathology and Laboratory Medicine
Cincinnati Children's Hospital Medical Center
240 Albert Sabin Way
Cincinnati, OH 45229-3039
Phone: (513) 636-4203 **Fax:** (513) 803-5014

PATIENT INFORMATION

THE FOLLOWING INFORMATION IS REQUIRED FOR EACH SAMPLE

Patient Name: _____ , _____ , ___
Last First MI

Date of Birth (MM/DD/YYYY): _____ / _____ / _____

Patient ID/Med Rec #: _____

Address: _____

City: _____ State: _____ Zip: _____

Preferred Phone: (_____) _____

Other # Where Patient can be Reached: (_____) _____

Sex: ☐ Male ☐ Female ☐ Unknown

Parent Name (if patient is minor): _____

Spouse: _____

Ethnicity of Patient (check all that apply):

☐ African American ☐ Asian ☐ Caucasian NW European ☐ E Indian

☐ Hispanic ☐ Ashkenazi Jewish ☐ Sephardic Jewish ☐ Mediterranean

☐ Native American ☐ NativeHawaiian/Other Pacific Islander ☐ Other

List Medications:

Is the patient currently on URSO® or ACTIGALL® (ursodiol), or has been within the past month? If yes, please provide the DATES of medication: _____

_____

Clinical History/Preliminary Diagnosis: _____

_____

_____

_____

_____

_____

_____

ICD-10: _____

CRITERIA FOR FREE TESTING

Please check boxes and attest:

Patient must meet one of the following:

Diagnosis of Zellweger Spectrum Disorder

☐ Zellweger Syndrome (severe)

☐ Neonatal Adrenoleukodystrophy (moderate/intermediate)

☐ Infantile Refsum Disease (mild)

I hereby attest that the patient meets the attached criteria and is a candidate for the Atypical Bile Acid Test via LC-MS. I understand the diagnostic testing services offered under this program are directional in nature and that they do not eliminate the need for additional medical management or replace any existing diagnostic methods. I further understand that neither Mirum Pharmaceuticals, Inc. nor Cincinnati Children's Hospital makes any claims as to the usefulness of this test.

Signature _____