

HEALTH CARE PROVIDER INFORMATION

How can pharmacogenetic testing help you and your patient?

Read on to learn more about TreatGx^{plus}!

WHAT IS TREATGX^{plus} AND HOW WILL THIS HELP MY PATIENT?

TreatGx^{plus} is an all-in-one product that includes the myPGx pharmacogenetic test, comprehensive pharmacogenetic reports, and clinician access to the TreatGx clinical decision-support software. By testing for specific, clinically actionable genetic variants, TreatGx^{plus} can give you the automated tools to personalize your patients' medication therapy and get them on the road to recovery faster. Using pharmacogenetics, in combination with other patient-specific information, will help you identify medications and medication doses that are likely to be the safest and most effective for your patient's specific condition **both now and in the future**. *Contact us if you do not have TreatGx integrated into your electronic medical record or pharmacy management system and would like to learn more.*

THE PHARMACOGENETIC TEST AND REPORT

The myPGx pharmacogenetic test includes over 60 genetic variants associated with altered response to more than 150 commonly used medications. The comprehensive reports include information on how your patient's pharmacogenetic results may affect their response to each medication. Every drug-gene association also includes a level of evidence from the PharmGKB database, as well as references to the Health Canada drug label or clinical studies when relevant.

THE TREATGX SOFTWARE

The TreatGx clinical decision support software includes more than 45 evidence-based treatment algorithms for conditions commonly treated in primary care. Each algorithm uses the most up-to-date evidence and guidelines to offer medication treatment options that are personalized for your patient based on pharmacogenetics, current medications, comorbid conditions, age, weight, kidney and liver function, and other relevant clinical factors. See <https://www.genxys.com/conditions-and-medications/> for a full list of conditions and medications included in the software.

A SIMPLE PROCESS

1. **Complete both the GS special authorization form and the GenXys pharmacogenetic patient consent form** (included in this package).
2. **Fax the special authorization form to GS at 1.866.797.6483** on behalf of your patient and **fax the completed and signed patient consent form directly to GenXys at 1.855.910.0813**. (If approved by GS, the patient will receive a promo code including details on how to order the test and submit their sample.)
3. Create a health care provider account by visiting <https://cdn.portal.genxys.com> and registering with GenXys to access the TreatGx software.
4. When the results of the test are ready, the health care practitioner will receive a faxed summary report, along with an email notification. (The patient can also log in to their patient account to invite additional health care providers to view their results.)
5. Access your health care provider account to view your patient's profile, including their pharmacogenetic test report and recommendations, and to create personalized and optimized medication options using the TreatGx software.

For more information, see the Resources pages at www.genxys.com.





PHARMACOGENETIC (PGx) TESTING - GenXys TreatGx^{plus}

SPECIAL AUTHORIZATION REQUEST FORM

Please note: Incomplete and/or missing information may delay the processing of your request.

SECTION 1 – PATIENT INFORMATION

Surname	GreenShield I.D. #	Employer Name
First Name	Date of Birth (Y/M/D)	Telephone Number
Street Address	City	Province Postal Code

I hereby authorize any licensed physician/dentist, pharmacist, medical practitioner, hospital, clinic or medically related facility, to provide to GreenShield information regarding my health as it relates to this request.

I hereby authorize GreenShield to obtain and exchange personal information with other parties as required, including any health care provider, patient assistance program and/or preferred pharmacy network (PPN) vendor working with GreenShield for the purpose of administering this benefit. I acknowledge that my personal information is needed to assess eligibility for this drug, to administer the group benefits plan, and where applicable, to administer pharmacy preferred provider network and patient support programs on my behalf. I acknowledge that my personal information may be exchanged and transferred between these parties for these purposes and may include information about my prescription drug claims, diagnosis, medical condition, treatment, and other health related information. I acknowledge that providing my consent will help GreenShield to assess my claim and that refusing to consent may result in delay or denial of my claim. This consent may be revoked by me at any time by sending written instructions to that effect at the address indicated below.

I understand that personal information may be subject to disclosure to those authorized under applicable law within Canada only when the information is needed to administer this benefit and/or to confirm the accuracy of this information.

I certify that the information given is true, correct, and complete to the best of my knowledge.

Date _____ Signature of Patient _____

(If under 16 years of age, the signature of the parent / guardian is required.)

SECTION 2 - HEALTH CARE PROVIDER INFORMATION

Health Care Provider Name	Health Care Provider Signature	Specialty or Pharmacy Name	Date (Y/M/D)
Street Address		Telephone Number	
City	Province	Postal Code	Fax Number

SECTION 3 – INFORMATION REQUESTED FOR EVALUATION

For the management of moderate to severe major depressive disorder and/or anxiety disorder (generalized or social) who have not responded appropriately to at least one prior medication (of adequate dose and duration¹).

Diagnosis being treated and disease severity:

Major depressive disorder

Generalized or social anxiety disorder

	Severity Level	PHQ-9 ² Score
<input type="checkbox"/>	Minimal	0-4
<input type="checkbox"/>	Mild	5-9
<input type="checkbox"/>	Moderate	10-14
<input type="checkbox"/>	Moderately Severe	15-19
<input type="checkbox"/>	Severe	20-27

	Severity Level	GAD-7 ³ Score
<input type="checkbox"/>	Minimal	0-4
<input type="checkbox"/>	Mild	5-9
<input type="checkbox"/>	Moderate	10-14
<input type="checkbox"/>	Severe	15-21

Prior treatment details:

Name of prior treatment: _____

Dose and timeframe used: _____

Results from prior treatment: _____

¹ Adequate duration defined as a treatment duration (at a therapeutic dose) of at least 4-6 weeks

² Patient Health Questionnaire-9 (PHQ-9) is a 9-item self-report questionnaire used to assess the nine diagnostic criteria of depression. (PHQ-9; Kroenke et al., 2001)

³ General Anxiety Disorder-7 (GAD-7) is a 7-item self-report questionnaire used to assess generalized anxiety disorder symptoms severity. (GAD-7; Spitzer et al., 2006)

Additional medication details (if applicable):

Please provide us with information on other coverage (provincial or private) as it pertains to this patient and medication:

Applied for coverage: Yes No Approved Denied

SECTION 4 - MAILING INSTRUCTIONS

Once completed, return request form along with any original paid "Official Pharmacy" receipts to:
 GreenShield, Drug Special Authorization Department, P.O. Box 1606, Windsor ON N9A 6W1
 Forms can be faxed or emailed: Fax: 1.519.739.6483 or Toll Free: 1.866.797.6483 or Email: drugspecial.autho@greenshield.ca

THE COST, IF ANY, OF OBTAINING THIS INFORMATION IS AT THE EXPENSE OF THE PATIENT/PLAN MEMBER.

Pharmacogenetic Patient Consent Form

GenXys Health Care Systems Inc., Vancouver, BC - Canada

e: info@genxys.com w: www.genxys.com

Patient Information

Last Name: _____	First Name: _____
Date of Birth: _____ MM / DD / YYYY	Sex at Birth: <input type="checkbox"/> M <input type="checkbox"/> F
Health Card #: _____	
Address:	
_____ Number	_____ Street
_____ City	_____ Province
	_____ Apt. _____ Postal Code
Telephone: _____	E-mail: _____

Patient Consent (mandatory)

I confirm that I have followed the sample collection instructions provided in the specimen collection kit to the best of my abilities. I acknowledge that my sample and personal health information will be sent to GenXys Health Care Systems Inc. (GenXys) for the purpose of pharmacogenetic testing. I understand that GenXys will contact me for a new sample if a test result cannot be provided from the original sample. I understand that I will be contacted by GenXys to obtain consent should GenXys be asked to disclose my information for another reason, other than as required or permitted by law. I have read and understand the Test Limitations, Privacy Statement and Disclaimer set out below.

Patient Signature: _____ **Date:** _____
MM / DD / YYYY

Send Copy of Results to Health Care Provider (optional)

Last Name: _____	First Name: _____
Licence #: _____ Provider ID/College ID	
Clinic/Pharmacy: _____	
Address:	
_____ Number	_____ Street
_____ City	_____ Province
	_____ Unit _____ Postal Code
Telephone: _____	Fax: _____
Required	Required

Instructions

1. **Prepare:** Before taking the test do not eat, drink, smoke, chew gum, use mouthwash or brush your teeth for at least 30 minutes. Rinse your mouth with water before using the test.
2. **Take sample:** Open package and remove the cheek swab from the tube (do not touch the swab tip). Insert the tip of the swab into the mouth and firmly rub it against the side of the cheek for a minimum of 30 seconds. Repeat on the other side of the mouth. Avoid rubbing the teeth.
3. Return used cheek swab to the tube.
4. **Label tube:** Apply the barcode sticker lengthwise to the tube, ensuring the barcode is parallel to the length of the tube.
5. Place the collection tube with your sample in the specimen bag and seal it.
6. Place the specimen bag with the collection tube in the same box the kit came in.
7. **Check** that everything is complete:
 - Collection tube with barcode inside specimen bag
 - Sealed specimen bag with completed identification label inside the box
 - This consent form with matching barcode should be put in the box
 - Seal the box using the adhesive strip
8. **Mail:** After collecting your sample, mail it as soon as possible. Drop the package off at any Canada Post Mailbox; the return box is pre-addressed and pre-paid.

What Is Done with My Sample After Testing Is Complete?

No additional clinical testing will be performed on your sample other than those authorized by your health practitioner. GenXys will disclose the test results only to the health practitioner listed on this form, unless otherwise authorized by you or as required by laws, regulations, or judicial order.

Test Limitations

This is not a diagnostic test, and TreatGx is not a prescribing system. You should discuss your pharmacogenetic information with a healthcare practitioner before you act upon the pharmacogenetic information resulting from this test. The medication brand names included in the pharmacogenetic report are not an exhaustive list and do not include combination therapies. Not all medications included in the pharmacogenetic report are included in the GenXys applications.

The report includes alleles of proteins involved in the metabolism of many medications. In rare cases, a variant that is not covered may be typed as *1 or other variants. In the case of pseudogenes and mutations in the untranslated regions of genes, incorrect allele typing may occur despite proper SNP detection. Preferential amplification of one allele over another present in the sample may also lead to incorrect genotyping.

Privacy Statement

The personal information collected on this form and all data subsequently resulting from the test, including pharmacogenetic information, will be used for quality assurance management and disclosed to the health practitioners involved in providing care, and otherwise used and disclosed only as permitted or required by the British Columbia Personal Information Protection Act and all related acts and regulations. Our privacy policies are available at www.genxys.com.

Disclaimer

We believe that you and your health practitioner should be partners in determining how to integrate the information from the pharmacogenetic test into your treatment plan taking all other factors (medical history, drug history, and other biophysical factors) into consideration.