Cincinnati Children's
changing the outcome together

Test Requisition Form [Required]

Bile Acid Synthesis Disorders

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 Travere Therapeutics , Inc.

SAMPLE/SPECIMEN INFORMATION

Sample Type: Urine (1 – 25 mL)

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

Internal Use only:

Received date: _____

FL#: _____

FAB#: _____

SHIPPING INFORMATION

Shipment Requirements:

- **US SHIPMENTS ONLY**
- **SHIP FROZEN**
  - ON ICE PACKS OR
  - DRY ICE
- **OVERNIGHT EXPRESS**
  - NO WEEKEND DELIVERY

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

Because Ursodeoxycholic acid can mask detection of bile acid synthetic disorders, the patient should be temporarily taken off URSO® or ACTIGALL® (ursodiol) for 5 DAYS before sample collection.

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:

☐ Pathogenic Variant or VOUS from a genetic test on one of the following genes:
- HSD3B7, AKR1D1, AMACR, CYP7B1

☐ Negative result on genetic test but patient has GGT≤150 IU/L and direct bilirubin >1 mg/dL

I hereby attest that the patient meets the attached criteria and is a candidate for the Atypical Bile Acid Test via FAB-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 Travere Therapeutics, Inc. nor Cincinnati Children's Hospital makes any claims as to the usefulness of this test.

Signature: _____