HIV-1 Nucleic Acid Amplification Test

Ordering Mnemonic:	3954, HIV-1 Nucleic Acid Amp Test
Methodology:	Polymerase chain reaction by COBAS Ampliprep/TaqMan v2.0
Preferred Specimen:	EDTA (Lavender top) (Draw 3 Lavender-top EDTA tubes)
Minimum Specimen Volume:	5.0 mL plasma
Transport:	Refrigerated, to arrive within 24 hours from collection
Reject Due to:	Sample received frozen in EDTA tube; heparinized plasma; serum; plasma not separated within 24 hours

When to order the **HIV-1 Nucleic Acid Amplification Test**:

- The initial HIV-1/HIV-2 test results are:
  - HIV EIA Screen: **Reactive**
  - HIV-1/HIV-2 Differentiation Test: **Non-reactive**
    Interpretation: Inconclusive. Reactive HIV-1/HIV-2 screen result could not be confirmed by the differentiation test; may be due to acute or early infection or false positive screen. Recommend repeat HIV antigen/antibody testing and HIV-1 RNA testing.

OR

- The initial HIV-1/HIV-2 test results are:
  - HIV EIA Screen: **Reactive**
  - HIV-1/HIV-2 Differentiation Test: **HIV-1 Indeterminate, HIV-2 Indeterminate, or HIV Indeterminate**
    Interpretation: Inconclusive. Reactive HIV-1/HIV-2 screen result could not be confirmed by the differentiation test; may be due to acute or early HIV-1 infection or false positive screen. Recommend repeat HIV antigen/antibody testing and HIV-1 RNA testing.

OR

- The initial HIV-1/HIV-2 test results are:
  - HIV EIA Screen: **Reactive**
  - HIV-1/HIV-2 Differentiation Test: **HIV-1 and HIV-2 Reactive, Undifferentiated**
    Interpretation: Evidence of HIV infection is present but unable to differentiate antibodies as HIV-1 or HIV-2; recommend referral testing for HIV-1 RNA and HIV-2 RNA or DNA to verify or rule-out dual infection.

OR

- The initial HIV-1/HIV-2 test results are:
  - HIV EIA Screen: **Non-reactive**
- **AND** acute HIV infection is suspected.

OR

- Determined as appropriate by the HIV/STD Division.

1. HIV-1 Nucleic Acid Amplification test requires **pre-approval by the HIV/STD Division**.
2. If testing is found to be appropriate, the HIV/STD Division will provide you with a test requisition form for the OSDH-contracted referral laboratory - **Clinical Pathology Laboratories** (**CPL**).
3. Schedule CPL Courier Service pick-up on the day prior to the patient's scheduled appointment.

> **Note: blood drawn for HIV testing must arrive at CPL within 24 hours of collection**; therefore, the patient's appointment time should be carefully scheduled (preferably in the early morning) to allow for pick-up by the courier and timely delivery to the testing laboratory.
>
> **Call the CPL Courier Service the day before the scheduled appointment to ask for specimen pick-up on the next day: Tulsa area: 1-800-891-2917 OKC area: 1-405-943-4616**
>
> ****If you are at one of 14 sites that rely solely on the SureXpress Courier Service, ensure that the patient's specimen is drawn and packaged prior to the regularly scheduled pick-up time.**

4. Fill-out (print) the following mandatory fields on the **CPL Test Requisition Form** (see next page pink highlighted areas):
    - Left-side of form:
        - Date Collected
        - Patient Name (Last, First, Middle)
        - Sex
        - Date of Birth (mm/dd/year)
        - Time of Collection
        - AM or PM
    - Right-side of the form:
        - Circle: Rhoades, Edd 60500 ordering Physician
    - Middle of form:
        - Site Code
        - Test Name; mark **3954 HIV 1 Nucleic Acid AMP test**
5. Specimen Collection:
    a. Label three (3) lavender-top **EDTA tubes** with the following:
        - Patient's Name
        - Date of Collection
        - Your Initials

    

    b. Draw the patient's blood into labeled EDTA tubes. The tube should be full.
    c. Gently, invert the tube five (5) times.
    d. Drawing 3 Lavender top-top EDTA tubes allows for enough plasma for testing
6. Prepare the specimen for courier pick-up as follows:
    a. Place the EDTA tube in a leak-proof "Specimen" bag.
    b. Fold the test requisition form, and slide it into the outer pocket of the bag.
    c. Mark the outside of the bag "24 Hour Handling Required".
    d. Store the bagged specimen in the refrigerator (do not freeze) until pick-up by the courier.

PLEASE PRINT WITH BLUE OR BLACK INK

CLINICAL PATHOLOGY LABORATORIES

D0141223

Clinical Accn Label

MOD 071916

55997

405 271 9444

OK STATE DEPT OF HLTH: HIV-HEPATITIS-STD
1000 NE 10TH ST
OKLAHOMA CITY, OK 73117

RHOADES
60500

Patient Name - Last | First | M.I.

Patient I.D. | Room # | Daytime Phone/Add'l ID

Date of Birth required | Sex | Date Collected | Time Collected | AM PM

Requesting Physician | Fasting | Urine Volume | STAT CALL Same Day

BILL TO: MEDICARE ACCOUNT MEDICAID PATIENT HMO PPO / POS

__ST __GY __PE __U __UC __SC __OP
__L __GR __SE __CU __SW __VT __F
__B __PR __Froz_____ __AP __OT

920 Venipuncture CPL 925 Finger / Heel Stick PSC ID
919 Venipuncture 922 Ur Vol Meas
997 Verbal Diagnosis 996 Standing Order Phleb ID
9999 Verbal Order ABN Attachments
989 Pt Decline 998 Multiple Orders

PLEASE COMPLETE INFORMATION BELOW

Policy Holder Name | Address | City, State, Zip | Evening Phone

REQUIRED | REQUIRED | REQUIRED

Medicare Number (Include Prefix/Suffix) | Medicaid Number | State | Ordering Physician NPI | PHYSICIAN'S SIGNATURE

REQUIRED | REQUIRED | REQUIRED | REQUIRED

Primary Insurance Name | Member I.D. | Group | Date of Injury or Onset of Illness

B5 Rev 2015

Primary Insurance Address | City, State, Zip | Phone | Authorization #

Secondary Insurance Name | Member I.D. | Group | Secondary Insurance Address | City, State, Zip | Phone

ICD Code REQUIRED | ICD Code | ICD Code | ICD Code | ICD Code | ICD Code | ICD Code | ICD Code | ICD Code

Physicians (or other individuals authorized by law to order tests) should only order tests that are medically necessary for the diagnosis or treatment of the patient.
*Reflex testing may be performed with additional charge (see reverse for details) @ Medicare Limited Coverage # Medicare Frequency Limit + Not Covered by Medicare > More than one CPT code will be billed

SITE CODE: _____

	TEST CODE	TEST NAME	TUBE TYPE	SPECIMEN TYPE	TRANSPORT TEMP	CENTRIFUGE
[ ]	6031	CULTURE, GC	SWAB	SOURCE _____	ROOM TEMP	NO
[ ]	4557	HCV RFLX QNT, RFLX GENO *(QNT>1000)	ST	SERUM	REFRIG	YES
[ ]	2730	HEP B CORE Ab RFLX IgM *	ST	SERUM	REFRIG	YES
[ ]	10837	HEP B SURFACE Ag&Ab, QL PROFILE *@#	ST	SERUM	REFRIG	YES
[ ]	3650	HIV-2 BY PCR, QUAL @	L	WHOLE BLOOD	ROOM TEMP	NO
[ ]	3954	HIV-1 NUCLEIC ACID AMP TEST @	L	PLASMA	REFRIG	YES

FAX RESULTS TO:

5375 ☐ QUAD Scrn @> ST
2617 ☐ AFP-NTD @ ST

Patient DOB: ___/___/___
Donor DOB: ___/___/___
Maternal Weight: _____
Testing: ☐ Initial ☐ Repeat
NTD History: ☐ Yes ☐ No

Pre-existing Insulin Dependent DM: ☐ Yes ☐ No
Race: ☐ CAU ☐ H ☐ AA ☐ Asian ☐ Other_____
Current Smoker: ☐ Yes ☐ No
Number of Fetuses: _____
If Twins: ☐ Dichorionic ☐ Monochorionic

Gestational Age (G.A.) Determined by (check):
☐ Sonogram: Date of Sonogram ___/___/___
G.A. at Sonogram _____ wks _____ days
☐ LMP: ___/___/___
Family History of Down Syndrome: ☐ Yes ☐ No

AP=APTIMA B=BLUE TOP TUBE BC=BLOOD CULTURE BOTTLE BP=BRONCH PATHOLOGY
ALL SPECIMENS MUST BE LABELED WITH PATIENTS NAME AND SECOND IDENTIFIER

OP=OVA AND PARASITE PRESERVATIVE SC=STOOL CULTURE PRESERVATIVE SP=SPUTUM ST=SERUM SEPARATOR TUBE SW=SWAB UC=URINE TUBE UC=URINE CULTURE TUBE VT=VIRAL TRANSPORT
MOS SPECIMEN MUST REFRIG ATED; F INDICAT CRITIC FROZEN INDIC S CRIT ROOM EMP CK www PLLABS M FOR TAILS