trio-smart®

PHONE: (855) 888-1230 | **EMAIL:** support@triosmartbreath.com

BREATH TESTING FOR THE THREE PRIMARY FERMENTED GASES

trio-smart is a **mail-in breath test** that measures the levels of **hydrogen, methane,** and **hydrogen sulfide** in a patient's breath after lactulose or glucose consumption. Measuring the three primary fermented gases can offer you clearer insight leading to a personalized treatment plan more quickly.

trio-smart is a validated Laboratory Developed Test **(LDT)** and is conducted in a **CLIA-certified** laboratory.

The **American College of Gastroenterology Clinical Guidelines for Small Intestinal Bacterial Overgrowth** provide authoritative validation of the value of breath testing technology like trio-smart and support mail-in kits with testing in CLIA-certified labs.

AJG The American Journal of GASTROENTEROLOGY

The North American Consensus on Hydrogen and Methane-Based Breath Testing in Gastrointestinal Disorders establishes common standards utilized by trio-smart.

INDICATIONS & CORRELATIONS

HYDROGEN
Indicative of:
Small Intestinal Bacterial Overgrowth (SIBO)

Correlated with:
No correlation with symptoms

METHANE
Indicative of:
Intestinal Methanogenic Overgrowth (IMO)

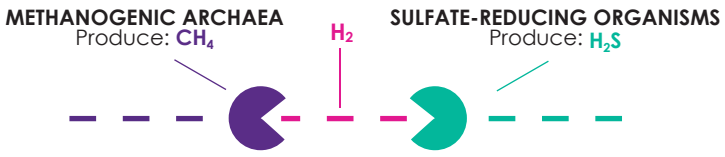
Correlated with:
Constipation

HYDROGEN SULFIDE
Indicative of: **Excess Hydrogen Sulfide**
Correlated with: **Diarrhea**

INTERPLAY OF THESE FERMENTED GASES

Hydrogen is produced by fermenting bacteria, but is also consumed by other organisms, resulting in the production of other gases, including **methane** and **hydrogen sulfide.**

These findings are important, because they suggest that **providers cannot rely solely on hydrogen** measurements, as they are directly affected by methane and hydrogen sulfide.



ORDER trio-smart

Please complete the attached requisition form and email it to **support@triosmartbreath** or fax it to **818-301-3222**. You can also order online by visiting **ordertriosmart.com**. Easy-to-interpret results are reported within seven days of sample receipt.

1. Pimentel, Mark, et al. **ACG Clinical Guideline: Small Intestinal Bacterial Overgrowth**. The American Journal of Gastroenterology, 2020.
2. Rezaie, Ali, et al. **Hydrogen and Methane-Based Breath Testing in Gastrointestinal Disorders: The North American Consensus**. The American Journal of Gastroenterology, 2017.
3. Pimentel, Mark, et al. **Gas and the Microbiome**. Current Gastroenterology, 2013.
4. Pimentel, Mark, et al. **Exhaled Hydrogen Sulfide Is Increased in Patients With Diarrhea: Results of a Novel Collection and Breath Testing Device**. AGA Abstracts, 2021.
5. Singer-Englar, Tahli, et al. **Validation of a 4-Gas Device for Breath Testing in the Determination of Small Intestinal Bacterial Overgrowth**. AGA Abstracts, 2021.

trio-smart Breath Test Requisition Form

ACCOUNT#: _____

trio-smart®
Fax requisition to: (818) 301-3222
Questions? support@triosmartbreath.com

PATIENT INFORMATION

Name: _____ (First / MI / Last)
Address 1: _____

Date of Birth: _____ (mm/dd/yyyy)
Address 2: _____

Sex (Male, Female): _____
City: _____ State: _____ Zip: _____

Email: _____
Phone: _____

PATIENT'S INSURANCE INFORMATION

Check one:

PLEASE PROVIDE FRONT & BACK COPY OF INSURANCE CARD.

☐ **HMO, PPO, Commercial Insurance***
Provider: _____ Policy #: _____

Policyholder: ☐ Self ☐ Other: _____ (Relationship to Patient (e.g., "Spouse," "Parent"))

Name: _____ (Policyholder Info (if Other))

Date of Birth: _____ Sex (Male, Female): _____

☐ **Medicare / Medicaid***
Subscriber ID: _____

☐ **Cash Pay ($289)** - Patient will be billed directly via mail.

An insurance claim for **$289** will be filed on the patient's behalf. Patients with private insurance will be billed the balance of the cost not covered by insurance. Patients with Medicare or Medicaid will be billed copays or coinsurance, if applicable.

PATIENT SIGNATURE (REQUIRED)

I authorize any physician or lab who has treated me or my dependent(s) to furnish any medical information requested. In consideration of services rendered, I transfer and assign any benefits of insurance to Pacific Diagnostics. I understand I am responsible for any co-pay or deductible amounts. I understand I am fully responsible for payment of my account if Pacific Diagnostics is not a participant with my health plan, and my health plan does not fully reimburse my medical services for any reason.

SIGN HERE _____ **DATE** _____
PATIENT SIGNATURE

ORDERING PRESCRIBER INFORMATION

Prescriber or Clinic Account Name: _____
Address 1: _____

(If Clinic Account) Reference Prescriber: _____
Address 2: _____

NPI: _____
City: _____ State: _____ Zip: _____

DELIVER TEST RESULTS TO: _____ (Enter Email Address or Fax Number)
Phone: _____

LABORATORY TEST ORDERED

☒ **trio-smart** CPT code: 91065

Substrate (required): _____ (Lactulose or Glucose)

PacificDx
5 Mason, Suite 100, Irvine, CA 92618
Laboratory Director: Shelly Gunn, MD, PhD

SUBSTRATE RX

If you have ordered a lactulose breath test, **please provide your patient with a prescription** for one dose of **10gm/15ml solution of lactulose.**

If you have ordered a glucose breath test, one dose of **75gm solution of glucose** will be **included in the sample collection kit.**

ICD-10 DIAGNOSIS CODE (REQUIRED)

☐ **R14.3** (Flatulence) ☐ **R14.0** (Abdominal Distension) ☐ **R14.2** (Eructation) ☐ **R10.9** (Abdominal pain) ☐ **K58.8** (IBS) ☐ **K58.0** (IBS-D) ☐ **K58.2** (IBS-M) ☐ **K58.9** (IBS with no diarrhea)

Other: _____ _____ _____

PRESCRIBER SIGNATURE (REQUIRED)

As the ordering prescriber named above, I certify that the patient whose specimen is being submitted for analysis has been informed of the benefits and limitations of the laboratory test(s) requested, has had the opportunity to have all questions answered adequately, and, if required by my institution, has given informed consent.

SIGN HERE _____ **DATE** _____
PRESCRIBER SIGNATURE