Inform Diagnostics Genomic Test Requisition

Shaded fields are required.

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INFORM DIAGNOSTICS

CLIENT INFORMATION

PATIENT INFORMATION

Last Name	First Name	MI	Age	Sex	Date of Birth / /
Street Address	Apt#	City	State	ZIP	
Phone #	Medical Record #	Physician Signature			

BILLING INFORMATION – PRIMARY INSURED

☐ SECONDARY Please check box and attach copy of front and back of patient's card.

We file all primary and secondary insurance plans if information is provided.

Required for all claim processing: Copy of front and back of patient's insurance card.

Payer ❍ Medicare ❍ Insurance ❍ Patient ❍ Client ❍ Other _____

Patient Status ❍ Non-hosp ❍ Hosp in-patient ❍ Hosp out-patient

Insurance Carrier	Pre-authorization Code	Policy Number/Insured ID Number	Group Number
Policy Holder's Name		Policy Holder's Relationship to Patient ❍ Self ❍ Spouse ❍ Dependent	Policy Holder's DOB / /

CLINICAL HISTORY

ICD CODE(S)

ETHNICITY

❍ African-American ❍ Hispanic
❍ White ❍ Jewish (Ashkenazi)
❍ Asian ❍ Jewish (Sephardic)

PATIENT PERSONAL HISTORY OF CANCER

Please attach clinical notes including personal and/or familial history of cancer.

❍ No personal history of cancer

Type of Cancer _____

Cancer Location _____

Age at Diagnosis _____

FAMILY HISTORY OF CANCER

Please indicate relationship, maternal or paternal, site of cancer, age at diagnosis.
Please indicate if bilateral, premenopausal or triple-negative breast cancer.

❍ No known family history

Relationship	Maternal	Paternal	Cancer Site	Age at Dx
	❍	❍		
	❍	❍		
	❍	❍		
	❍	❍		
	❍	❍		

SPECIMEN INFORMATION

Date of Collection: _____

❍ **Peripheral Blood** (EDTA Purple Top)

❍ **Saliva** (Oragene DNA Kit)

SPECIMEN REQUIREMENTS

Acceptable Specimen Type	Saliva Oragene DNA Self Collection Kit	Peripheral Blood 3–5 mL EDTA Tube
BRCA1 and BRCA2 Screening	✓	✓
High-Risk Hereditary Breast Cancer Panel	✓	✓
OncAware Complete		✓

GENOMIC TESTS* *Complete list of genes on reverse*

❍ BRCA1 and BRCA2 Screening ❍ High-Risk Hereditary Breast Cancer Panel (7 genes) ❍ OncAware Complete (27 genes)

INFORMED CONSENT AND REFERRAL FOR CANCER GENETIC COUNSELING

I certify that the patient specified above, or his or her legally authorized representative, has been informed of the risks, benefits and alternatives to the laboratory test(s) requested. I have answered the patient's questions and otherwise obtained and documented the patient's consent in accordance with applicable law.

Patient will be referred for genetic counseling if required by payor as part of prior-authorization. By ordering genetic counseling, the undersigned person represents that he/she is a licensed medical professional authorized to order genetic counseling OR is a representative of a licensed medical professional authorized to order genetic counseling; acknowledges the patient has been supplied information regarding the benefits of genetic counseling and the patient has given consent for genetic counseling to be performed. The undersigned understands that a certified genetic counselor will provide the counseling, prepare a written report summarizing the consultation, will provide a copy of the report to the undersigned for inclusion in the medical record and will provide a copy of the report to the performing laboratory for billing purposes.

Healthcare Professional Signature _____ Date _____

PATIENT ACKNOWLEDGEMENT OF COVERAGE

Testing and specimen will be placed on hold until verification of benefits or prior authorization with insurance provider is completed. If services are covered by my insurance provider and patient responsibility is estimated to be less than $100, Inform Diagnostics will proceed with testing. I understand that I am financially responsible for any amounts not covered (co-pay, deductible, etc.). I understand that I will only be contacted by Inform Diagnostics to determine if test should be performed or canceled if testing is not covered by my insurance provider or if patient responsibility is estimated to exceed $100.

NOTE: For Medicare patients, please also complete the ABN Form. ***Testing is not covered by all providers and will be processed and billed based on payor criteria.**

Patient Signature _____ Date _____

Patient Phone Number _____

In keeping with the requirements of Medicaid and Medicare, it is the policy of Inform Diagnostics only to perform testing that is medically necessary for the diagnosis and treatment of patient.

6655 N. MacArthur Blvd., Irving, TX 75039 / 866.588.3280 / Fax: 866.688.3280 / CLIA 45D0975010
4207 E. Cotton Center Blvd., Phoenix, AZ 85040 / 855.856.0656 / Fax: 855.856.0655 / CLIA 03D1064744

Billing/Lab (White) Client (Yellow)

FOR LAB USE ONLY

Patient: _____ DOB: _____ 00000000	Patient: _____ DOB: _____ 00000000
Patient: _____ DOB: _____ 00000000	Patient: _____ DOB: _____ 00000000

Molecular/Genomic Tests

BRCA1 and BRCA2 Screening: BRCA1, BRCA2

High-Risk Hereditary Breast Cancer Panel (7 genes): BRCA1, BRCA2, CDH1, PALB2, PTEN, STK11, TP53

OncAware Complete (27 genes): APC, ATM, BARD1, BMPR1A, BRCA1, BRCA2, BRIP1, CDH1, CDK4, CDKN2A, CHEK2, EPCAM, MLH1, MRE11A, MSH2, MSH6, MUTYH, NBN, PALB2, PMS2, PTEN, RAD50, RAD51C, RAD51D, SMAD4, STK11, TP53

Criteria for Referral for Cancer Genetic Evaluation

Use this form to help determine if your patient meets criteria for referral for cancer genetics evaluation. Inform Diagnostics often can use this information, in addition to clinical notes, for prior authorization requests.

When completing this form, evaluate cancer history on both sides of the family, including the following:

- Patient's cancer history
- First-degree relatives (parents, siblings, children)
- Second-degree relatives (aunts, uncles, nieces, nephews, grandparents) *and*
- Third-degree relatives (cousins, great-grandparents, great-aunts and uncles)

Clinical History

Has your patient had prior germline genetic testing for cancer? ☐ Yes ☐ No If yes, coverage may be denied.

Per the NCCN Guidelines, to meet criteria for further genetic risk evaluation, AT LEAST ONE of the below criteria must be met. Meeting criteria does not guarantee that payors will cover testing but increases likelihood of coverage.

Check all criteria that apply. Meeting one or more criteria indicates likely coverage.

Personal history of breast cancer	☐ Diagnosed ≤ 50 ☐ Triple negative breast cancer ☐ Ashkenazi Jewish ancestry ☐ 2 breast primaries ☐ Male breast cancer ☐ Received genetic testing for HBOC prior to 2007
Personal history of colorectal cancer	☐ Diagnosed ≤ 50 ☐ Abnormal IHC and/or microsatellite instability ☐ History of multiple colonic polyps (>10) ☐ Prior history of cancer
Personal history of endometrial cancer	☐ Diagnosed ≤ 50 ☐ Abnormal IHC and/or microsatellite instability
Personal history of any single case of	☐ Ovarian/fallopian tube/primary peritoneal cancer ☐ Adrenocortical carcinoma ☐ Wilms tumor (bilateral) ☐ Choroid plexus carcinoma ☐ Diffuse gastric cancer ☐ Leiomyosarcoma ☐ Sebaceous carcinoma ☐ Hepatoblastoma ☐ Pediatric rhabdoid tumor: kidney or brain ☐ Optic glioma
Family history of	☐ Relative with a mutation in a hereditary cancer susceptibility gene ☐ Three or more of the same type of cancer on one side of family (any type—melanoma, prostate, pancreatic, renal, etc.)
Personal or family history of multiple cancer types that include any of the following combinations	☐ Breast, ovarian, prostate, pancreas, and/or melanoma ☐ Colon, uterine, stomach, ovarian, pancreas, small bowel, brain, sebaceous neoplasia, and/or urinary tract cancers ☐ Lobular breast cancer, diffuse gastric, and/or colon cancer ☐ Breast, follicular thyroid, uterine, renal, colon, skin, and/or GI polyps ☐ Multiple colon polyps (>=10) ☐ Breast, sarcoma, brain, adrenocortical, and/or leukemia

These criteria are meant to be used as a general guide. Indications listed above for further genetic risk evaluation are in accordance with the National Comprehensive Cancer Network (NCCN) and other professional societal guidelines, but not all indications for hereditary cancer risk assessment are listed. Please contact Client Services if you have additional questions.