Test Requisition Form – Oncology

Hematology

fulgent | INFORM DIAGNOSTICS — A FULGENT GENETICS COMPANY

Highlighted fields are required information

PATIENT INFORMATION

Last Name	First Name	MI
Street Address		Apt#
City	State	Zip
Phone	DOB	Sex
Patient MR#		

CLIENT INFORMATION

INSURANCE/BILLING INFORMATION

Attach a copy of the patient's demographic sheet, both sides of the patient's insurance card(s) and all secondary insurance information (if applicable).

BILL TO:

☐ Medicare ☐ MediCal ☐ Insurance ☐ Patient/Self Pay ☐ Client Billing

IPA/MED GROUP AFFILIATION

PRIOR AUTHORIZATION NUMBER

ICD-10 CODE(S)

ICD-10 information is required

Physician Notice: Only tests or diagnostic services that are medically necessary should be ordered. Appropriate ICD-10 information must be in the specified area to the left. Payers, including Medicare and Medicaid, generally do not pay for screening tests. ABN is required for Medicare patients if ICD-10 codes provided do not support reasoning for testing.

PERTINENT INDICATION OR CLINICAL HISTORY

Please provide relevant patient reports

CLINICAL HISTORY/INDICATIONS AND NARRATIVE DIAGNOSIS/CLINICAL DATA

Please attach copy of recent CBC, copy of doctor's notes/clinical history, pathology reports, and any relevant test results

- ☐ Acute Lymphoblastic Leukemia
  - ☐ B-Cell ☐ T-Cell
  - ☐ Lineage Uncertain
- ☐ Acute Myeloid Leukemia
- ☐ Anemia
- ☐ Blast Cells in Blood
- ☐ Chronic Lymphocytic Leukemia
- ☐ Chronic Myeloid Leukemia
- ☐ Chronic Myelomonocytic Leukemia
- ☐ Eosinophilia
- ☐ Hodgkin Lymphoma
- ☐ Leukemia, Unspecified
- ☐ Leukocytosis, Unspecified
- ☐ Leukopenia
- ☐ Lymphadenopathy
- ☐ Lymphocytosis
- ☐ Monoclonal Gammopathy
- ☐ Monocytosis
- ☐ Myeloma, Plasma Cell
- ☐ Myelodysplastic Syndrome
- ☐ Myeloproliferative Neoplasm
- ☐ MDS/MPN Neoplasm
- ☐ Neutrophilia
- ☐ Non-Hodgkin Lymphoma
- ☐ Polycythemia
- ☐ Suspected Malignant Neoplasm
- ☐ Thrombocytopenia

DIAGNOSIS

☐ New ☐ Follow up ☐ Remission ☐ History of ☐ Rule out

- ☐ AML
- ☐ MDS
- ☐ MPN
- ☐ CML
- ☐ B-ALL
- ☐ T-ALL
- ☐ CLL/SLL
- ☐ B-NHL (type) _____
- ☐ T-NHL (type) _____
- ☐ Hodgkin Lymphoma
- ☐ Hepatosplenomegaly
- ☐ Bone Lesions
- ☐ Skin Lesions
- ☐ Carcinoma (type)
- ☐ Other _____

PREVIOUS CYTOGENETICS/FISH

- ☐ Normal
- ☐ Allogeneic Bone Marrow Transplant
  - Donor Sex: ☐ Male ☐ Female
- ☐ Abnormal (please provide report)
- ☐ Autologous Bone Marrow Transplant

THERAPY

Current Therapy Prior (>1 month ago)

- ☐ Anti-CD19 Therapy
- ☐ Anti-CD Therapy
- ☐ Anti-CD30 Therapy
- ☐ Anti-CD18 Therapy
- ☐ Erythropoietin Therapy
- ☐ G-CSF

SPECIMEN INFORMATION

Indicate number of tubes, vials, slides or tissue blocks provided

PATIENT STATUS WHEN SPECIMEN COLLECTED (must choose one): ☐ Hospital Inpatient ☐ Hospital Outpatient ☐ Non-Hospital Outreach/Clinic Patient

Date of Collection: ___/___/___ AM PM Body Site

Bone Marrow Biopsy: Core # Clot # Touch Preparations #

Bone Marrow Aspirate: Green-top(s) (Na Heparin) # Purple-top(s) (EDTA) # Smears #

Peripheral Blood: Green-top(s) (Na Heparin) # Purple-top(s) (EDTA) # Smears #

Tissue Biopsy: Tissue Type/Location _____ ☐ Paraffin Block ☐ Formalin Fixed ☐ Fresh in RPMI ☐ Fresh in Saline Specimen ID# _____

Other (CSF, FNA, Body Fluid, etc. – include location): _____

COMPREHENSIVE HEMATOLOGICAL EVALUATION RECOMMENDED

☐ **Comprehensive Bone Marrow or Peripheral Blood Diagnostic Analysis‡**

Hematopathologist will determine medically appropriate testing, including NGS testing, based on clinical data and morphologic findings.

FLOW LAB PARTNERSHIP PROGRAM

If participating in the Flow Lab Partnership Program, please select level of service below

Flow Cytometry: Leukemia/Lymphoma Panel ☐ My Lab Performs Flow Cytometry ☐ Inform Diagnostics Performs Flow Cytometry

INDIVIDUAL DIAGNOSTIC/PROGNOSTIC TESTS

Select individual tests below

Morphology/Microscopic Evaluation
Selected stains will be performed as medically necessary
☐ Morphology Evaluation ☐ Consult

Flow Cytometric Analysis
☐ Leukemia/Lymphoma Panel
☐ Prognostic panel ZAP-70 for CLL—Blood Only
☐ Prognostic panel for PNH Evaluation—Blood Only

Cytogenetic Analysis†
☐ Cytogenetic Analysis with reflex to FISH if clinically indicated

Fluorescence In Situ Hybridization (FISH)‡
☐ AML ☐ MDS ☐ CML (BCR/ABL) ☐ Eosinophilia ☐ B-ALL ☐ T-ALL
☐ CLL ☐ B-Cell NHL ☐ PCM ☐ MPN ☐ DLBCL ☐ APL STAT
☐ CD5(-)/CD10(-) ☐ Marginal Zone/MALT1 ☐ Burkitt ☐ Mantle Cell
☐ Follicular ☐ Anaplastic Large Cell ☐ Individual Probes (see reverse)
☐ Other _____

†Peripheral blood is not an optimal specimen for Cytogenetics or FISH except for CLL and CML.

Molecular Testing (with Interpretation)
☐ Heme NGS Profile (Includes DNA and RNA Sequencing)
Note: This test is performed as part of the Comprehensive Hematological Evaluation service when medically necessary

CML or B-ALL
☐ BCR-ABL1 Screening p190, p210 (no previous results)
☐ BCR-ABL1 Follow-up (select one): ☐ p190 ☐ p210
☐ ABL Kinase Domain Mutation (Including T315I)
(for patients with known and treated disease only)

Myeloproliferative Neoplasms
☐ MPN Panel
(JAK2 V617F reflex to JAK2 Exon 12, CALR and/or MPL W515K/L/A as medically appropriate)

AML
☐ AML Prognostic Panel (known AML diagnosis only)
(FLT3 and NPM1 with reflex to CEBPA)
☐ Perform IDH1/IDH2 as part of AML Panel

APL Monitoring
☐ Quantitative PML/RARA (48-hour stability)

Mastocytosis
☐ KIT (D816V) Mutation by dPCR (0.1% AF)

Lymphoproliferative Disorder
☐ B-Cell Clonality/Gene Rearrangement
☐ T-Cell Clonality/Gene Rearrangement
☐ IGHV Mutation Analysis (CLL)
☐ MYD88 L265P (Waldenstrom/Lymphoplasmacytic)
☐ BRAF (HCL)

☐ Other _____

Contact 855.856.0656 or HemeClientServices@InformDx.com to arrange specimen pickup. See reverse for optimal specimen requirements and FISH probes.

4207 E. Cotton Center Blvd., Phoenix, AZ 85040 / 855.856.0656 / Fax 855.856.0655 / CLIA 03D1064744 / MLS-20-0529.3 5/23

Inform Diagnostics/Fulgent Oncology (White) Client Copy (Yellow)

1. Complete all requested information on requisition. **2.** Use appropriate number of labels provided. **3.** Place one label on each specimen and dispose of the remaining labels.

A1 HE-0000001	B2 HE-0000001	C3 HE-0000001	D4 HE-0000001
Pt. Name _____	Pt. Name _____	Pt. Name _____	Pt. Name _____
DOB___/___/___ PB A	DOB___/___/___ PB	DOB___/___/___ PB A	DOB___/___/___ PB A
E5 HE-0000001	**F6 HE-0000001**	**G7 HE-0000001**	**H8 HE-0000001**
Pt. Name _____	Pt. Name _____	Pt. Name _____	Pt. Name _____
DOB___/___/___ PB A	DOB___/___/___ PB A	DOB___/___/___ PB A	DOB___/___/___ PB A
I9 HE-0000001	**J10 HE-0000001**	**K11 HE-0000001**	**L12 HE-0000001**
Pt. Name _____	Pt. Name _____	Pt. Name _____	Pt. Name _____
DOB___/___/___ PB A	DOB___/___/___ PB A	DOB___/___/___ PB A	DOB___/___/___ PB A

Please discard extra labels

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Hematology

HEMATOLOGY/ONCOLOGY OPTIMAL SPECIMEN REQUIREMENTS

The matrix below indicates the optimal specimens required for testing. Please include as many specimens as possible for each technology. For a complete and timely analysis, please include all recommended specimen types.

TEST/TECHNOLOGY	BONE MARROW CORE	BONE MARROW CLOT	BONE MARROW ASPIRATE	PERIPHERAL BLOOD	PERIPHERAL BLOOD SMEAR	LYMPH NODES/ FRESH TISSUE	FIXED TISSUE (PARAFFIN BLOCK W/H&E)	FLUIDS	STORAGE & TRANSPORT
Comprehensive Bone Marrow Analysis	Place in 10% formalin	Place in 10% formalin	2–3 ml in green-top (sodium heparin) tube AND 0.5–1.0 ml in purple-top (EDTA) tube	2–3 ml in purple-top (EDTA) tube and CBC (a CBC will be performed if not submitted)	2 freshly prepared smears preferred				Store at room temperature. Use FROZEN cold pack for transport.
Comprehensive Bone Marrow Analysis (Dry Tap)	One (1) core in formalin and one (1) core in RPMI [§]			2–3 ml in green-top (sodium heparin) tube AND 2–3 ml in purple-top (EDTA) tube	2 freshly prepared smears preferred				Store at room temperature. Use FROZEN cold pack for transport.
Comprehensive Peripheral Blood Analysis				2–3 ml in green-top (sodium heparin) tube AND 2–3 ml in purple-top (EDTA) tube	2 freshly prepared smears preferred				Store at room temperature. Use FROZEN cold pack for transport.
Morphology	At least four (4) touch preparations (air-dried). Place core in 10% formalin	Place in 10% formalin	4–5 freshly prepared smears preferred AND 1 ml aspirate in purple-top (EDTA)	2–3 ml in purple-top (EDTA) tube and CBC (a CBC will be performed if not submitted)	2 freshly prepared smears	Place in 10% formalin	Representative paraffin block		Store at room temperature. Use FROZEN cold pack for transport.
Flow Cytometry			2–3 ml in purple-top (EDTA) tube preferred	2–3 ml in purple-top (EDTA) tube preferred		Representative tissue in RPMI [§] or saline		Representative fluid	Store at room temperature. Use FROZEN cold pack for transport.
ZAP-70 for CLL or PNH Evaluation				2–3 ml in purple-top (EDTA) tube preferred					Store at room temperature. Use FROZEN cold pack for transport.
Immunohistochemistry (IHC)	Place in 10% formalin	Representative paraffin block				Place in 10% formalin	Representative paraffin block		Store at room temperature. Use FROZEN cold pack for transport.
Cytogenetics – Karyotype			2–3 ml in green-top (sodium heparin) tube	2–3 ml in green-top (sodium heparin) tube Peripheral blood is not an optimal specimen for Cytogenetics except for CLL and CML					Store at room temperature. Use FROZEN cold pack for transport.
Fluorescence in situ Hybridization (FISH)			3 ml in green-top (sodium heparin) preferred or purple-top (EDTA) tube	3 ml in green-top (sodium heparin) preferred or purple-top (EDTA) tube Peripheral blood is not an optimal specimen for FISH except for CLL and CML					Store at room temperature. Use FROZEN cold pack for transport.
Molecular (PCR, Sequencing)			2–3 ml in purple-top (EDTA) tube	2–3 ml in purple-top (EDTA) tube			Representative paraffin block		Store at room temperature. Use FROZEN cold pack for transport.

[§] DO NOT use RPMI if it is cloudy, yellow or is at or beyond expiration date. Use only pink/orange RPMI. If RPMI is not available, use saline.

FISH: The panels are designed to detect the most common abnormalities for a given disease group. Additional probes may be added, as medically necessary, to further characterize abnormalities found in the primary panel(s). Peripheral blood is not an optimal specimen for Cytogenetics or FISH except for CLL and CML.

AML RPN1/MECOM [inv(3)/t(3;3)/ ins(3;3)] RUNX1T1(ETO)::RUNX1(AML1) [t(8;21)] KMT2A (MLL) (11q23.3) PML::RARA [t(15;17)] CBFB [inv(16)/t(16;16)]	**MDS** EGR1 (5q31) D7S522 (7q31) CEN 8 D20S108 (20q12) Reflex RPN1/MECOM [inv(3)/t(3;3)/ ins(3;3)] KMT2A (MLL) (11q23.3) RB1(13q14.2)/LAMP1(13q34) TP53 (17p13.1)	**CML** BCR::ABL1 [t(9;22)]	**Eosinophilia** PDGFRA (4q12) PDGFRB (5q32–q33) FGFR1 (8p11.23) JAK2 (9p24.1)	**B-ALL** PBX1::TCF3 [t(1;19)] CEN 4 CDKN2A (p16) (9p21.3)/CEN 9 BCR::ABL1 [t(9;22)] CEN 10 KMT2A (MLL) (11q23.3) ETV6(TEL)::RUNX1(AML1) [t(12;21)]]	**T-ALL** CDKN2A (p16) (9p21.3)/CEN 9 BCR::ABL1 [t(9;22)] KMT2A (MLL) (11q23.3) TP53 (17p13.1)	**CLL** MYB (6q23.3) ATM (11q22.3) CCND1::IGH [t(11;14)] CEN 12 D13S319 (13q14.3) TP53 (17p13.1))
B-Cell NHL BCL6 (3q27) MYC (8q24) CCND1::IGH [t(11;14)] MALT1 (18q21) IGH::BCL2 [t(14;18)] Bone marrow aspirate and FFPE are acceptable specimen types	**PCM** CKS1B/CDKNC (1q21/1p32.3) CEN 9 CEN 11 CCND1::IGH [t(11;14)] RB1(13q14.2)/LAMP1(13q34) IGH (14q32) TP53 (17p13.1) Reflex FGFR3::IGH [t(4;14)] IGH::MAF [t(14;16)] IGH::MAFB [t(14;20)]	**MPN** EGR1 (5q31) D7S522 (7q31) CEN 8 CDKN2A (p16) (9p21.3)/CEN 9 BCR::ABL1 [t(9;22)] RB1(13q14.2)/LAMP1(13q34) D20S108 (20q12)	**DLBCL-Double, Triple Hit** BCL6 (3q27) MYC (8q24) MYC::IGH [t(8;14)] BCL2 (18q21.33) IGH::BCL2 [t(14;18)]	**APL STAT** PML::RARA [t(15;17)] RARA ! TAT 24 hours	**CD5(–)/CD10(–) Lymphoproliferative** BCL6 (3q27) D7S522 (7q31) CEN 12 IGH (14q32) TP53 (17p13.1) MALT1 (18q21)	**Marginal Zone/MALT1** BCL6 (3q27) CEN 12 IGH (14q32) BIRC3::MALT1[t(11;18)] MALT1 (18q21) FFPE or fresh tissue only
Burkitt Lymphoma MYC (8q24)	**Mantle Cell Lymphoma** CCND1::IGH [t(11;14)]	**Follicular Lymphoma** IGH::BCL2 [t(14;18)]	**Anaplastic Large Cell Lymphoma** ALK (2p23) If negative, reflex to: TP63 (3q28) IRF4/DUSP (6p25.3)	**Additional Available Probes** HER2/CEN17 ROS1, MET, RET Melanoma (CCND1, RREB1, MYB, CEN 6, CDKN2A, CEN 9) Oligodendroglioma (1p/19q) Undecalcified Formalin-Fixed Tissues Only		

[†] Inform Diagnostics medical staff will select the number and type of antibodies, other reagents or probes that are necessary. In keeping with the requirements of Medicaid and Medicare, it is the policy of Inform Diagnostics to only perform testing that is medically necessary for the diagnosis and treatment of the patient. Medicare does NOT pay for routine screening tests.

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