MEDEX LABORATORIES

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PLEASE SUBMIT THE FOLLOWING WITH REQUISITION FORM

- ☐ Letter of Medical Necessity (Signed by Physician)
- ☐ Informed Consent Form (Signed by Pt & Physician)
- ☐ SOAP & Progress Note (Signed by Physician)
- ☐ Summary of Active Medications
- ☐ Scanned Insurance Card Copy

CANCERGENOMICS TESTING REQUISITION FORM

COMPLETE ENTIRE FORM AND SUBMIT PEDIGREE/CLINIC NOTES TO AVOID DELAYS

PATIENT INFORMATION

IMPORTANT - Include a current medication list AND a patient face sheet OR complete next two sections below and include photocopy of insurance card (front and back).

First Name	Last Name	Gender F ☐ M ☐
Date of Birth (MM/DD/YYYY)	Phone	Email
Address	City	State / Zip

Ethnicity: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Jewish(Ashkenazi) ☐ Portuguese ☐ Other

PATIENT INSURANCE INFORMATION

- Attach patient demographics and copy of insurance card

☐ Insurance ☐ Self-Pay ☐ Client Bill

Primary Insurance	Social Security Number
Primary Insurance ID#	Primary Insurance Group

SPECIMEN INFORMATION*

Date Sample Collected (mm/dd/yy) (required)

Medical Record#

☐ Buccal Swab

☐ Other (specify source)

ORDERING PHYSICIAN/SENDING FACILITY (Each Listed person will receive a copy of the report)

Facility Name (Facility Code)		Address	
City	State/Country	Zip	Phone
Ordering Provider Name (Last, First)	NPI#	Phone/Fax/Email	

STATEMENT OF MEDICAL NECESSITY

By submission of this test requisition and accompanying sample(s), I: (i) authorize and direct to perform the testing indicated; (ii) certify that the person listed as the ordering provider is authorized by law to order the test(s) requested; (iii) certify that any custom panel and/or ordered test(s) requested on this test requisition form are reasonable and medically necessary for the diagnosis and/or treatment of a disease, illness, impairment, symptom, syndrome or disorder; (iv) the test results will determine my patient's medical management and treatment decisions of this patient's condition on this date of service; (v) have obtained this patient's and relatives', when applicable, written informed consent to undergo any genetic testing requested; and (vi) that the full and appropriate diagnosis code(s) are indicated to the highest level of specificity.

Signature of Provider (required) Date:

INDICATIONS FOR TESTING (CHECK ALL THAT APPLY)

☐ Diagnostic ☐ Family history ☐ Positive or normal control ☐ Other.....

Will Patient management be changed depending on the test results? ☐ Yes ☐ No ☐ STAT TEST : Date results needed (if known):.....

CLINICAL HISTORY Attach any available detailed medical records and clinical notes

Please indicate any clinical presentations and/or Endings that may be relevant to genetic testing:

There are many presentations which may not seem like a direct association for disease. Please list the most suspected presentations and attach detailed medical records and/or pedigree.

PATIENT VISIT HISTORY

Date of the Previous Patient Visit	Date of the Last Genetic Testing, if any

PATIENT CLINICAL HISTORY

Cancer /Tumer	Age at DX	Pathology and Other info
Breast		Type: ER☐ (+)☐(-)☐ unk PR☐ (+)☐ (-) ☐ unk HER2/neu ☐ (+) ☐(-) ☐ unk
2nd primary breast		Type: ER☐ (+)☐(-)☐ unk PR☐ (+)☐ (-) ☐ unk HER2/neu ☐ (+) ☐(-) ☐ unk
Ovarian		Fallopian tube Primary peritoneal
Prostate		Gleason score:
Hematologic		Type: Allogeneic bone marrow or peripheral stem cell transport
Other Cancer		Type:

Other clinical history:

Pre- Genetic Counselling:

Please Refer case to a genetic counselling institution if Genetic counseling is required by patients benefits.

TARGETED SINGLE GENE TESTING PANEL

☐ APC	☐ BRCA1	☐ CDKN2A	☐ GREM1	☐ MUTYH	☐ POLD1	☐ SMAD4
☐ ATM	☐ BRCA2	☐ CHEK2	☐ MITF	☐ NBN	☐ POLE	☐ STK11
☐ BAP1	☐ BRIP1	☐ COL1A1	☐ MLH1	☐ NF1	☐ PTEN	☐ TP53
☐ BARD1	☐ CDH1	☐ EPCAM	☐ MSH2	☐ PALB2	☐ RAD51C	
☐ BMPR1A	☐ CDK4	☐ FBN1	☐ MSH6	☐ PMS2	☐ RAD51D	

INDICATION (S) FOR TESTING (ICD-10 Codes)

☐ C25.1	Malignant neoplasm of body of Pancreas	☐ C61	Malignant neoplasm of prostate
☐ C25.4	Malignant neoplasm of endocrine pancreas	☐ D05.12	Intraductal carcinoma in situ of left breast
☐ C25.9	Malignant neoplasm of pancreas, unspecified	☐ Z85.07	Personal history of malignant neoplasm of pancreas
☐ C50.011	Malignant neoplasm of nipple and areola, female breast	☐ Z85.03	Personal history of malignant neoplasm of breast
☐ C50.021	Malignant neoplasm of nipple and areola, male breast	☐ Z85.43	Personal history of malignant neoplasm of ovary
☐ C50.111	Malignant neoplasm of central portion of female breast	☐ Z85.46	Personal history of Malignant neoplasm of prostate
☐ C50.121	Malignant neoplasm of central portion of male breast	☐ Z15.01	Genetic susceptibility of breast
☐ C50.211	Malignant neoplasm of upper-inner quadrant of female breast	☐ Z15.02	Genetic susceptibility of ovary
☐ C50.221	Malignant neoplasm of upper-inner quadrant of male breast	☐ Z15.03	Genetic susceptibility of prostate
☐ C50.311	Malignant neoplasm of upper-inner quadrant of female breast	☐ Z15.04	Genetic susceptibility of endometrium
☐ C50.321	Malignant neoplasm of upper-inner quadrant of male breast	☐ Z15.09	Genetic Susceptibility to other malignant neoplasm
☐ C50.411	Malignant neoplasm of upper-inner quadrant of female breast	☐ Z15.81	Genetic susceptibility to Multiple endocrine neoplasia (Men)
☐ C50.422	Malignant neoplasm of upper-inner quadrant of male breast	☐ Z15.89	Genetic susceptibility to Other disease
☐ C50.811	Malignant neoplasm of overlapping sites of female breast	☐ Z80.0	Family history of malignant neoplasm of digestive organs
☐ C50.911	Malignant neoplasm of unspecified site of female breast	☐ Z80.3	Family history of malignant neoplasm of breast
☐ C50.919	Malignant neoplasm of unspecified site of unspecified female breast	☐ Z80.41	Family history of malignant neoplasm of ovary
☐ C50.921	Malignant neoplasm of unspecified site of male breast	☐ Z80.42	Family history of malignant neoplasm of prostate
☐ C50.929	Malignant neoplasm of unspecified site of unspecified male breast	☐ Z80.43	Family history of malignant neoplasm of testis
☐ C56.1	Malignant neoplasm of ovary	☐ Z80.49	Family history of malignant neoplasm of other genital organs
☐ C56.9	Malignant neoplasm of unspecified ovary	☐ Z80.59	Family history of malignant neoplasm of other urinary tract organ
☐ C57.01	Malignant neoplasm of right Fallopian tube		

INFORMED CONSENT

For the purposes of this consent, "I", "my", and "your" will refer to me or to my child, including my unborn child, if my child is the person for whom the healthcare provider has ordered testing.

PURPOSE OF THIS TEST

The purpose of this test is (a) to see if I may have a genetic variant or chromosome rearrangement causing a genetic disorder; or (b) to evaluate the chance that I will develop or passon a genetic disorder in the future. If I already know the specific gene variant(s) or chromosome rearrangement that causes the genetic disorder in my family, I agree to inform the laboratory of this information.

WHAT TYPE OF TEST RESULTS CAN I EXPECT FROM GENETIC TESTING?

1. Positive: A change in your DNA was found, which is very likely the cause of your features/symptoms. This is the most straightforward test result, which can be used as the basis to test other family members to determine their chances of having either the disease or a child with the disease.

2. Negative: No variants were found to explain your symptoms. This does not mean that you do not have a genetic condition. It is still possible that there is a genetic variant not found by the test that was ordered. Your healthcare provider or genetic counselor may discuss more testing either now or in the future.

3. Variant of Uncertain Significance (VUS): A change in a gene was found. However, we are not sure whether this variant is the cause of your symptoms/-features. More information is needed. We may suggest testing other family members to help figure out the meaning of the test result.

4. Unexpected Results: In rare instances, this test may reveal an important genetic change that is not directly related to the reason for ordering this test. For example, this test may find you are at risk for another genetic condition I am not aware of or it may indicate differences in the number or rearrangement of sex chromosomes. We may disclose this information to the ordering healthcare provider if it likely affects medical care. Because medical and scientific knowledge is constantly changing, new information that becomes available may supplement the information **Medex Laboratories Inc.** used to interpret my results.

Healthcare providers can contact **Medex Laboratories Inc.** at any time to discuss the classification of an identified variant.

WHAT IS TRIO/DUO-BASED GENETIC TESTING?

For some genetic tests, including samples from the biological parents and/or other biological relatives along with the patient's sample can help with the interpretation of the test results. These tests are often referred to as "trio tests" since they typically include samples from the patient and both parents. Samples from relatives should be submitted with the patient's sample. Clinical information must be provided for the patient and any relative who submits a sample.

I understand that **Medex Laboratories Inc.** will use the relative sample(s) when needed for the interpretation of my test results and that my test report may include clinical and genetic information abouta relative when it is relevant to the interpretation of the test results. I further understand that relatives will not receive an independent analysis of data nor a separate report.

RISKS AND LIMITATIONS OF GENETIC TESTING

1. In some cases, testing may not identify a genetic variant even though one exists. This may be due to limitations in current medical knowledge or testing technology.

2. Accurate interpretation of test results may require knowing the true biological relationships in a family. I understand that if I fail to accurately state the biological relationships in my family, it could lead to incorrect interpretation of the test results, incorrect diagnoses, and/or inconclusive test results. If genetic testing reveals that the true biological relationships in a family are not as I reported them, including non-paternity (the reported father is not the biological father) and consanguinity (the parents are related by blood), I agree to have these findings reported to the healthcare provider who ordered the test.

3. Although genetic testing is highly accurate, inaccurate results may occur. These reasons include, but are not limited to mislabeled samples, inaccurate reporting of clinical/medical information, rare technical errors, or other reasons.

4. I understand that this test may not detect all of the long-term medical risks that I might experience. The result of this test does not guarantee my health and that additional diagnostic tests may still need to be done.

5. I agree to provide an additional sample if the initial sample is not adequate.

PATIENT CONFIDENTIALITY AND GENETIC COUNSELING

It is recommended that I receive genetic counseling before and after having this genetic test. I can find a genetic counselor in my area at www.nsgc.org. Further testing or additional consultations with a healthcare provider may be necessary.

To maintain confidentiality, test results will only be released to the referring healthcare provider, the ordering laboratory, to me, to other healthcare providers involved in my care, diagnosis and treatment, or to others with my consent or as permitted or required by law. Federal laws prohibit unauthorized disclosure of this information. More information can be found at: www.genome.gov/10002077

INTERNATIONAL SAMPLES

If I reside outside the United States, I attest that by providing a sample for testing, I am not knowingly violating any export ban or other legal restriction in the country of my residence.

SAMPLE RETENTION

After testing is complete, my sample may be de-identified and be used for test development and improvement, internal validation, quality assurance, and training purposes. **Medex Laboratories Inc.** will not return DNA samples to you or to referring healthcare providers, unless specific prior arrangements have been made. I understand that samples from residents of New York State will not be included in the de-identified research studies described in this authorization and will not retain them for more than 60 days after test completion, unless specifically authorized by my selection. The authorization is optional, and testing will be unaffected if I do not check the box for the New York authorization language. **Medex Laboratories Inc.** will not perform any tests on the biological sample other than those specifically authorized.

DATABASE PARTICIPATION

De-identified health history and genetic information can help healthcare providers and scientists understand how genes affect human health. Sharing this de-identified information helps healthcare providers to provide better care for their patients and researchers to make new discoveries. **Medex Laboratories Inc.** shares this type of information with healthcare providers, scientists, and healthcare databases. **Medex Laboratories Inc.** will not share any personally identifying information and will replace the identifying information with a unique code not derived from any personally identifying information. Even with a unique code, there is a risk that I could be identified based on the genetic and health information that is shared. **Medex Laboratories Inc.** believes that this is unlikely, though the risk is greater if I have already shared my genetic or health information with public resources, such as genealogy websites.

INFORMED CONSENT

EXOME/GENOME SEQUENCING SECONDARY FINDINGS

Applicable Only for Full Exome Sequencing and Genome Sequencing Tests. • Does not pertain to Xpanded® or Slice tests

As many different genes and conditions are analyzed in an exome or genome sequencing test, these tests may reveal some findings not directly related to the reason for ordering the test. Such findings are called "incidental" or "secondary" and can provide information that was not anticipated.

Secondary findings are variants, identified by an exome or genome sequencing test, in genes that are unrelated to the individual's reported clinical features.

The American College of Medical Genetics and Genomics (ACMG) has recommended that secondary findings identified in a specific subset of medically actionable genes associated with various inherited disorders be reported for all probands undergoing exome or genome sequencing. Please refer to the latest version of the ACMG recommendations for reporting of secondary findings in clinical exome and genome sequencing for complete details of the genes and associated genetic disorders. Reportable secondary findings will be confirmed by an alternate test method when needed.

WHAT WILL BE REPORTED FOR THE PATIENT? - All pathogenic and likely pathogenic variants associated with specific genotypes identified in the genes (for which a minimum of 10X coverage was achieved by exome sequencing or a minimum of 15X coverage was achieved by genome sequencing), as recommended by the ACMG.

WHAT WILL BE REPORTED FOR RELATIVES? - The presence or absence of any secondary finding(s) reported for the proband will be provided for all relatives analyzed by an exome or genome sequencing test.

LIMITATIONS - Pathogenic and/or likely pathogenic variants may be present in a portion of the gene not covered by this test and therefore are not reported. The absence of reportable secondary findings for any particular gene does not mean there are no pathogenic and/or likely pathogenic variants in that gene. Pathogenic variants and/or likely pathogenic variants that may be present in a relative, but are not present in the proband, will not be identified, or reported. Only changes at the sequence level will be reported in the secondary findings report. Larger deletions/duplications, abnormal methylation, triplet repeat or other expansion variants, or other variants not routinely identified by clinical exome and genome sequencing will not be reported.

FINANCIAL AGREEMENT AND GUARANTEE - For insurance billing, I understand and authorize **Medex Laboratories Inc.** to bill my health insurance plan on my behalf, to release any information required for billing, and to be my designated representative for purposes of appealing any denial of benefits. I irrevocably assign to and direct that payment be made directly to I understand that my out-of-pocket costs may be different than the estimated amount indicated to me by **Medex Laboratories Inc.** as part of a benefit investigation. I agree to be financially responsible for any and all amounts as indicated on the explanation of benefits issued by my health insurance plan. If my insurance provider sends a payment directly to me for services performed by **Medex Laboratories Inc.** on my behalf, I agree to endorse the insurance check and forward it to **Medex Laboratories Inc.** within 30 days of receipt as payment towards **v**claim for services rendered.

MEDICARE

A completed Advance Beneficiary Notice (ABN) is required for Medicare patients.

DIGITAL PATIENT LETTER CONSENT

• Applicable Only for Commercial Insurance

• Estimate is provided by your health insurance company and therefore NO estimate will be sent for any orders placed with federal or state-funded insurance plans (e.g. Medicare, Medicaid, Tricare, etc.), institutional bill, or patient bill (self-pay).

To provide you with the estimated out-of-pocket expenses related to your test, **Medex Laboratories Inc.** will send you an email and/or text with the link to access your personalized Digital Patient Letter.

In order to send this information, we need your consent and agreement to the following items:

1. can use your email address or mobile phone number solely for the purpose of **Medex Laboratories Inc.** sending your estimated financial obligation. Text message data rates may apply. is not responsible for undelivered messages due to incorrect or illegible contact information.

2. will send you an email and/or text message containing a link to view your personalized Patient Letter that includes the test out-of-pocket estimate. The link is time-sensitive and will only be available for 72 hours from the time the message is sent. In order to view the estimate, you must click the link in the message.

3. If you take no action, **Medex Laboratories Inc.** will assume that you agree to move ahead with testing and will bill your health insurance. You can approve testing with insurance, switch to self-pay, or cancel the test via the link within the given 72-hour window. In turn, **Medex Laboratories Inc.** if receives your sample(s) and the billing method hasn't been changed, or the test hasn't been cancelled, we will move ahead with testing as ordered, and you will be responsible for any out-of-pocket costs for the completion of the test(s).

PATIENT SIGNATURE

I hereby assign all rights and benefits under my health plan and all rights and obligations that I and my dependents have under my health plan to **Medex Laboratories Inc**. its assigned affiliates and authorized representatives for laboratory services furnished to me by **Medex Laboratories Inc.** I irrevocably designate, authorize and appoint **Medex Laboratories Inc.** or its assigned affiliates and their authorized representatives as my true and lawful attorney-in-fact for the purpose of submitting my claims, obtain a copy of my health plan document, Summary Plan Description, disclosure, appeal, litigation or other remedies in accordance with the benefits and rights under my health plan and in accordance with federal or state laws. If my health plan fails to abide by my authorization and makes payment directly to me, I agree to endorse the insurance check and forward it to **Medex Laboratories Inc.** immediately upon receipt. I hereby authorize **Medex Laboratories Inc.** its assigned affiliates and authorized representatives to contact me or my health Plan/administrator for billing or payment purposes by phone, text message, or email with the contact information that I have provided to **Medex Laboratories Inc.,** in compliance with federal and state laws. **Medex Laboratories Inc.**, its assigned affiliates and their authorized representatives may release to my health plan administrator, my employer, and my authorized representative my personal health information for the purpose of procuring payment of **Medex Laboratories Inc.** and for all the laboratory services. I understand the acceptance of insurance does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether or not they are covered by my insurance.

Signature of Patient or Patient Representative / Relationship to Patient Date:

ORDERING PHYSICIAN SIGNATURE

Physician must only order tests that are medically necessary for the diagnosis or treatment of a patient

I attest that this test is medically necessary for the diagnosis or detection of a disease or disorder and that the results will be used in medical management and care decisions for the patient. Furthermore, all information on this Requisition Form is true to the best of my knowledge. I agree to provide the Care Plan notes and Letter of Intent for this order if the insurance requests the lab to gather the medical necessity for any reason

Ordering Physician Signature Date: