Ambry Genetics™

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CLIA# 05D0981414
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INSURANCE ORDERING CHECKLIST

- ☐ Clinic Note(s) and Pedigree
- ☐ ICD-9 Codes
- ☐ Clinician & Patient Signatures
- ☐ Copy Patient Insurance Card

Breast Cancer Test Requisition (All Pink Fields Required)

PATIENT INFORMATION

Last Name	First Name	Middle Initial	DOB (MM/DD/YY)	Date of Death (if applicable)
Street Address	City	State	Zip	
Preferred Contact Phone Number	Gender ☐F ☐M ☐Unknown	Ethnicity ☐African American ☐Asian ☐Caucasian ☐Hispanic ☐Jewish (Ashkenazi) ☐Portuguese ancestry ☐Specify:_____		

SPECIMEN INFORMATION

Collection Date	Specimen ID	MRN

Specimen Type: ☐Blood (EDTA preferred) ☐Saliva (adult) ☐Saliva (pediatric) ☐DNA ☐Blood spots ☐Other

*We cannot accept blood or saliva for individuals who have undergone bone marrow or peripheral stem cell transplant or who have a current hematologic malignancy. Please submit cultured fibroblasts or fresh normal tissue.

ICD-9 CODES (FOR INSURANCE ONLY)	INDICATIONS FOR TESTING (CHECK ALL THAT APPLY)
	☐Diagnostic ☐Family history of cancer ☐Positive or normal control ☐Other_____

ORDERING PHYSICIAN AND/OR OTHER LICENSED MEDICAL PROFESSIONAL

Name (Last, First, Degree)	Facility Name	NPI#	
Street Address	City	State	Zip
Phone	Fax	E-mail	

FORM COMPLETED BY (MUST BE COMPLETED IF NOT ORDERING CLINICIAN)

☐ CHECK HERE FOR ADDITIONAL COPY OF RESULTS

Form Completed By	Phone	Fax	E-mail

ADDITIONAL RESULTS RECIPIENTS

Medical Professional Name	Phone	E-mail/Fax
Medical Professional Name	Phone	E-mail/Fax

CONFIRMATION OF INFORMED CONSENT AND MEDICAL NECESSITY FOR GENETIC TESTING

By ordering testing, the undersigned person represents that he/she is a licensed medical professional authorized to order genetic testing OR is a representative of a licensed medical professional authorized to order genetic testing; acknowledges the patient has been supplied information regarding genetic testing and the patient has given consent for genetic testing to be performed and the signed consent form is on file. I confirm that this is medically necessary for the diagnosis or detection of a disease, illness, impairment, syndrome or disorder, and that these results will be used in the medical management and treatment decisions for this patient. My signature here applies to the attached letter of medical necessity (if applicable). Furthermore, additional results recipients information is true and correct to the best of my knowledge.

Does this patient give consent to the use of their sample for research? ☐Yes ☐No Consent is implied if a box is not marked (For samples originating from New York State facilities, research consent will NOT be implied if left blank).

Medical Professional Signature _____ Date: _____

☐ INSURANCE BILLING (INCLUDE COPY OF BOTH SIDES OF INSURANCE CARD)

Patient Relation to Policy Holder? ☐Self ☐spouse ☐child	Name and DOB of Policy Holder	
Insurance Company	Policy #	HMO Authorization #

☐ PATIENT PAYMENT

☐Check (Payable to Ambry Genetics) ☐Visa ☐Mastercard ☐American Express ☐Discover

Card Number	Exp. Date	CVC #
Cardholder Name	Amount $	

☐ INSTITUTIONAL BILLING

Facility Name	
Street Address	
City	
State	Zip Code
Contact Name	
Phone Number	E-mail

Patient Acknowledgement: I acknowledge that the information provided by me is true to the best of my knowledge. For direct insurance/3rd party billing: I hereby authorize my insurance benefits to be paid directly to Ambry Genetics Corporation and authorize them to release medical information concerning my testing to my insurer. If applicable, I authorize Ambry Genetics Corporation to be my Designated Representative for purposes of appealing any denial of benefits. I understand that I am financially responsible for any amounts not covered by my insurer for this test order.

I also fully understand that I am legally responsible for sending Ambry Genetics any money received from my health insurance company for performance of this genetic test.

For patient payment by credit card : I hereby authorize Ambry Genetics Corporation to bill my credit card as indicated above.

Patient Signature: _____ Date: _____

Affix blue colored bar code label to TRF below. Affix matching numbered red colored bar code label to specimen. Please do not apply barcode sticker to small DNA vials.

bar code sticker 1 | bar code sticker 2 | bar code sticker 3 | Ambry use only

Breast Cancer Test Requisition

Patient Name_____

*Please make sure to indicate ethnicity on page 1

PATIENT CLINICAL HISTORY ☐ No personal history of cancer

☐ **Personal h/o Breast Cancer** Age at dx : _____ ☐ Bilateral

☐ *Check here if surgery is occurring within the month and genetic results will impact surgery. Surgery date (if known)* _____

☐ IDC (Invasive ductal carcinoma)
☐ ILC (Invasive lobular carcinoma)
☐ DCIS (Ductal carcinoma in situ)
☐ LCIS (Lobular carcinoma in situ)

ER ☐(+) ☐(-)
PR ☐(+) ☐(-)
HER2/neu ☐(+) ☐(-)

☐ **Personal h/o Ovarian Cancer** Age at dx : _____
☐ **Personal h/o Pancreatic Cancer** Age at dx : _____
☐ **Personal h/o Other Cancer, Type :** _____ Age at dx: _____
☐ **Other clinical hx:** _____
☐ **Personal h/o allogenic bone marrow or peripheral stem cell transplant**
☐ **Current diagnosis of heme malignancy, Type :** _____

PATIENT TESTING HISTORY ☐ No previous genetic testing

☐ Negative Ashkenazi Jewish *BRCA* 3-mutation panel
☐ Negative *BRCA1/2* gene sequencing only
☐ Negative *BRCA1/2* gene sequencing and large rearrangement
☐ Other: _____

FAMILY HISTORY

Maternal (mother's side) family history of cancer ☐ yes ☐ no ☐ unknown

Relation to patient	H/o cancer/polyps	Dx age

Paternal (father's side) family history of cancer ☐ yes ☐ no ☐ unknown

Relation to patient	H/o cancer/polyps	Dx age

Additional/Other (siblings/children) family history of cancer ☐ yes ☐ no ☐ unknown

Relation to patient	H/o cancer/polyps	Dx age

TEST MENU (IF MORE THAN 1 TEST IS ORDERED, THEY WILL BE RUN CONCURRENTLY UNLESS SEQUENTIAL IS INDICATED IN NOTES SECTION)

Hereditary Breast and Ovarian Cancer Syndrome*

☐ *BRCA1/2* gene sequence and deletion/duplication analyses(concurrent) — 8838

☐ **BRCAplus:** 5 breast cancer gene test *(BRCA1, BRCA2, CDH1, PTEN, TP53)* — 8836

☐ **BreastNext:** 17 breast cancer gene test *(ATM, BARD1, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, MRE11A, MUTYH, NBN, NF1, PALB2, PTEN, RAD50, RAD51C, RAD51D, TP53)* — 8820

☐ *BRCA1/2* Ashkenazi Jewish 3-site Mutation panel — 5892

☐ *BRCA1/2* Ashkenazi Jewish 3-site Mutation panel with reflex to *BRCA1/2* Analysis if negative — 5894

☐ *BRCA1/2* analysis with reflex to BRCAplus if negative — 8862

☐ *BRCA1/2* deletion/duplication analysis — 5890

☐ *BRCA1* Specific Site Analysis, mutation _____ — 5864
☐ *BRCA2* Specific Site Analysis, mutation _____ — 5884

Patient relationship to known mutation carrier _____
Please include a copy of the known mutation carrier's test report

☐ *PALB2* gene sequence and deletion/duplication — 2366

☐ *TP53* gene sequence and deletion/duplication — 2866

☐ *PTEN* gene sequence and deletion/duplication — 2106

Other Hereditary Cancer Panels*

☐ **GYNplus:** 9 ovarian/uterine cancer gene test *(BRCA1, BRCA2, EPCAM, MLH1, MSH2, MSH6, PMS2, PTEN, TP53)* — 8835

☐ **OvaNext:** 23 ovary/breast/uterine cancer gene test *(ATM, BARD1, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, EPCAM, MRE11A, MLH1, MSH2, MSH6, MUTYH, NBN, NF1, PALB2, PMS2, PTEN, RAD50, RAD51C, RAD51D, STK11, TP53)* — 8830

☐ **ColoNext:** 14 colon cancer gene test *(APC, BMPR1A, CDH1, CHEK2, EPCAM, MLH1, MSH2, MSH6, MUTYH, PTEN, PMS2, SMAD4, STK11, TP53)* — 8822

☐ **PancNext:** 13 pancreatic cancer gene test *(APC, ATM, BRCA1, BRCA2, CDKN2A, EPCAM, MLH1, MSH2, MSH6, PALB2, PMS2, STK11, TP53)* — 8042

☐ **RenalNext:** 18 renal cancer gene test *(EPCAM, FH, FLCN, MET, MITF, MLH1, MSH2, MSH6, PMS2, PTEN, SDHA, SDHB, SDHC, SDHD, TP53, TSC1, TSC2, VHL)* — 5900

☐ **PGLNext:** 10 PGL/PCC gene test *(MAX, NF1, RET, SDHA, SDHAF2, SDHB, SDHC, SDHD, TMEM127, VHL)* — 5504

☐ **CancerNext:** 28 cancer gene test *(APC, ATM, BARD1, BRCA1, BRCA2, BRIP1, BMPR1A, CDH1, CHEK2, CDK4, CDKN2A, EPCAM, MLH1, MRE11A, MSH2, MSH6, MUTYH, NBN, NF1, PALB2, PMS2, PTEN, RAD50, RAD51C, RAD51D, SMAD4, STK11, TP53)* — 8824

☐ **CancerNext-*Expanded*:** 43 cancer gene test *APC, ATM, BARD1, BRCA1, BRCA2, BRIP1, BMPR1A, CDH1, CDK4, CDKN2A, CHEK2, EPCAM, FH, FLCN, MAX, MET, MITF, MLH1, MRE11A, MSH2, MSH6, MUTYH, NBN, NF1, PALB2, PMS2, PTEN, RAD50, RAD51C, RAD51D, RET, SDHA, SDHAF2, SDHB, SDHC, SDHD, SMAD4, STK11, TMEM127, TP53, TSC1, TSC2, and VHL* — 8874

Notes:

REPORTING OPTIONS

☐ Do not include *BRCA1/2* sequencing results for this multi-gene panel order due to previous negative testing for this patient through another diagnostic laboratory. PLEASE NOTE: a copy of the previous negative *BRCA1/2* report MUST be included with the test requisition form for *BRCA1/2* sequencing results to be excluded from the final Ambry report. In addition, clinically significant *BRCA1/2* variants (i.e. those classified as "pathogenic" or "likely pathogenic") are always reported.

Billing ABN and Patient Protection Plan Information:

A completed Advance Beneficiary Notice (ABN) of coverage is required for Medicare patients who do not meet medical criteria for testing (see website for form).

Ambry Genetics preverifies insurance coverage and will contact the patient prior to initiating testing if the out-of-pocket amount for testing is estimated to exceed $100.*

*This does not apply to specific site analyses. Insurance preverification will not be performed for these tests, unless specifically requested.