

1. SPECIMEN INFORMATION

Collection Date
<input type="checkbox"/> Send saliva kit to patient

PLEASE SUBMIT THE FOLLOWING WITH THE TRF:

1. Clinic Notes 2. Pedigree 3. Insurance Card and Authorization Documents

2. PATIENT INFORMATION

Name (Last, First, MI)		Biological Sex <input type="checkbox"/> F <input type="checkbox"/> M	Date of Birth (MM/DD/YY)	MRN
Ethnicity: <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Portuguese <input type="checkbox"/> Other:				Ashkenazi Jewish <input type="checkbox"/> Yes <input type="checkbox"/> No
Address		City	State	Zip
Phone	Email		Preferred Billing <input type="checkbox"/> Insurance* <input type="checkbox"/> Self-pay <input type="checkbox"/> Institutional	

* Copy of front/back of insurance card and additional payer-specific authorization forms are required. Please complete Patient Assistance Program information below, if applicable.

3. ORDERING PROVIDER INFORMATION

Organization Name, Number	Address	City, State	Zip
Ordering Provider Name (Last, First), Ambry Number <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Genetic Counselor/Other Healthcare Professional Name (Last, First), Ambry Number <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

4. PATIENT CLINICAL HISTORY Attach clinic notes and/or pedigree

Personal History of Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Age of Dx	Diagnosis Notes (cancer type, etc.)	Metastatic <input type="checkbox"/> Yes <input type="checkbox"/> No	ICD-10 Code(s)
Family History of Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Family History Details (include relative, cancer type, and age of diagnosis)			
Prior Genetic Testing, IHC, or MSI <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient Testing Details		Family Members Testing Details	

5. TEST ORDER

Select the indication for testing: <input type="checkbox"/> Hereditary breast and ovarian cancer ¹ <input type="checkbox"/> Lynch ² <input type="checkbox"/> Hereditary polyposis ³ <input type="checkbox"/> None <input type="checkbox"/> Other: _____ <small>1. BRCA1/2 2. MLH1, MSH2, MSH6, PMS2, EPCAM 3. APC/MUTYH</small>	Select desired test: <input type="checkbox"/> BRCAplus® 8836 <input type="checkbox"/> BRCANext™ 8855 <input type="checkbox"/> BRCANext-Expanded™ 8860 <input type="checkbox"/> CancerNext® 8824 <input type="checkbox"/> CancerNext-Expanded® 8874 <input type="checkbox"/> ColoNext® 8822 <input type="checkbox"/> CustomNext-Cancer® 9510 <input type="checkbox"/> ProstateNext® 8845 <input type="checkbox"/> Other: _____ <input type="checkbox"/> Add +RNAinsight® to selected panel** <small>** Not available with BRCAplus or STAT orders; PAXgene® tube required for RNA</small>
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Optional: Add AmbyrScore® Breast (Additional Supplemental Ordering Form REQUIRED) Prostate

Will the course of treatment change depending upon the results of the test? Yes No STAT TEST: Date results needed (if known): _____

Patient Signature (I agree to terms below):	Date:
Medical Professional Signature (I agree to terms below):	Date:

TERMS AND CONDITIONS

Patient Acknowledgement: I acknowledge that the information provided by me is true and correct. For direct insurance billing: I authorize my insurance benefits to be paid directly to Ambyr Genetics Corporation (Ambyr), authorize Ambyr to release medical information concerning my testing to my insurer, to be my designated representative for purposes of appealing any denial of benefits as needed and to request additional medical records for this purpose. I understand that I am financially responsible for any amounts not covered by my insurer and responsible for sending Ambyr money received from my health insurance company.

We will start testing immediately, unless you check the box below. We will attempt to contact the patient if the estimated out-of-pocket costs are > USD \$100

Do not start testing until my patient approves payment terms regarding estimated out-of-pocket costs.

By checking this box, I understand that there will be a delay in starting this test until Ambyr is able to reach the patient to communicate OOP costs.

For patient payment by credit card: I hereby authorize Ambyr Genetics Corporation to bill my credit card as indicated above. In order to expedite consideration for eligibility for **Ambyr's Patient Assistance Program**, please provide the total annual gross household income: \$ _____ and the number of family members in the household supported by the listed income: _____. I authorize Ambyr Genetics Corporation to verify the above information for the sole purpose of assessing financial need, including the right to seek supporting documentation.

For NY residents: I am a New York resident and I give Ambyr Genetics permission to store my sample for longer than 60 days. **NOTE:** If left blank, consent is interpreted as "NO".

Medical Professional: Confirmation of Informed Consent, Pre-test Genetic Counseling, and Medical Necessity for Genetic Testing

The undersigned person (or representative thereof) ensures he/she is a licensed medical professional authorized to order genetic testing and confirms that the patient has given appropriate consent. I confirm that testing is medically necessary and that test results may impact medical management for the patient. I agree to allow Ambyr Genetics to facilitate the provision of pre-test genetic counseling services by a third-party service, as required by the patient's insurance provider. Furthermore, all information on this TRF is true to the best of my knowledge. My signature applies to the attached letter of medical necessity.

Blood/saliva from patients with a history of allogenic bone marrow or stem cell transplant cannot be used for genetic testing. Blood/saliva from patients with active hematological disease is not recommended. An alternative specimen may be needed. Please see ambrygen.com/specimen-requirements for details.

Supplemental Information

Hereditary Cancer Multi-Gene Tests

Test Name	Test Code	Genes
Adenomatous polyposis	8726	APC, MUTYH
BrainTumorNext® (29 genes)	8847	AIP, ALK, APC, CDKN1B, CDKN2A, DICER1, EPCAM, LZTR1, MEN1, MLH1, MSH2, MSH6, NBN, NF1, NF2, PHOX2B, PMS2, POT1, PRKAR1A, PTCH1, PTEN, SMARCA4, SMARCB1, SMARCE1, SUFU, TP53, TSC1, TSC2, VHL
BRCANext™^ (18 genes)	8855	ATM, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, EPCAM, MLH1, MSH2, MSH6, NBN, NF1, PALB2, PMS2, PTEN, RAD51C, RAD51D, TP53
BRCANext-Expanded™^ (23 genes)	8860	ATM, BARD1, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, DICER1, EPCAM, MLH1, MSH2, MSH6, NBN, NF1, PALB2, PMS2, PTEN, RAD51C, RAD51D, RECQL, SMARCA4, STK11, TP53
BRCAPlus® (8 genes)	8836	ATM, BRCA1, BRCA2, CDH1, CHEK2, PALB2, PTEN, TP53
CancerNext®^ (36 genes)	8824	APC, ATM, AXIN2, BARD1, BRCA1, BRCA2, BRIP1, BMPR1A, CDH1, CDK4, CDKN2A, CHEK2, DICER1, EPCAM, GREM1, HOXB13, MLH1, MSH2, MSH3, MSH6, MUTYH, NBN, NF1, NTHL1, PALB2, PMS2, POLD1, POLE, PTEN, RAD51C, RAD51D, RECQL, SMAD4, SMARCA4, STK11, TP53
CancerNext-Expanded®^ (77 genes)	8874	AIP, ALK, APC, ATM, AXIN2, BAP1, BARD1, BLM, BRCA1, BRCA2, BRIP1, BMPR1A, CDC73, CDH1, CDK4, CDKN1B, CDKN2A, CHEK2, CTNNA1, DICER1, EGFR, EGLN1, EPCAM, FANCC, FH, FLCN, GALNT12, GREM1, HOXB13, KIF1B, KIT, LZTR1, MAX, MEN1, MET, MIF, MLH1, MSH2, MSH3, MSH6, MUTYH, NBN, NF1, NF2, NTHL1, PALB2, PDGFRA, PHOX2B, POT1, PMS2, POLD1, POLE, PRKAR1A, PTCH1, PTEN, RAD51C, RAD51D, RB1, RECQL, RET, SDHA, SDHAF2, SDHB, SDHC, SDHD, SMAD4, SMARCA4, SMARCB1, SMARCE1, STK11, SUFU, TMEM127, TP53, TSC1, TSC2, VHL, XRCC2
ColoNext® (20 genes)	8822	APC, AXIN2, BMPR1A, CDH1, CHEK2, EPCAM, GREM1, MLH1, MSH2, MSH3, MSH6, MUTYH, NTHL1, PMS2, POLD1, POLE, PTEN, SMAD4, STK11, TP53
CustomNext-Cancer®^ (up to 91 genes) Required: complete CustomNext-Cancer supplemental form. ambrygen.com/forms	9510	ABRAXAS1 (FAM175A)†; AIP, ALK, APC, ATM, AXIN2, BAP1, BARD1, BLM, BRCA1, BRCA2, BRIP1, BMPR1A, CASR, CDC73, CDH1, CDK4, CDKN1B, CDKN2A, CFTR, CHEK2, CPA1, CTNNA1, CTRC, DICER1, EGFR, EGLN1, EPCAM, FANCC, FH, FLCN, GALNT12, GREM1, HOXB13, KIF1B, KIT, LZTR1, MAX, MEN1, MET, MIF, MLH1, MLH3†, MRE11A †, MSH2, MSH3, MSH6, MUTYH, NBN, NF1, NF2, NTHL1, PALB2, PALLD†, PDGFRA, PHOX2B, POT1, PMS2, POLD1, POLE, PRKAR1A, PRSS1, PTCH1, PTEN, RAD50 †, RAD51C, RAD51D, RB1, RECQL, RET, RINT1†, RPS20†, SDHA, SDHAF2, SDHB, SDHC, SDHD, SMAD4, SMARCA4, SMARCB1, SMARCE1, SPINK1, STK11, SUFU, TERT†, TMEM127, TP53, TSC1, TSC2, VHL, XRCC2
HBOC	8838	BRCA1, BRCA2
Lynch syndrome/HNPCC	8517	MLH1, MSH2, MSH6, PMS2 + EPCAM del/dup
MelanomaNext® (9 genes)	8849	BAP1, BRCA2, CDK4, CDKN2A, MIF, POT1, PTEN, RB1, TP53
PancNext® (13 genes)	8042	APC, ATM, BRCA1, BRCA2, CDKN2A, EPCAM, MLH1, MSH2, MSH6, PALB2, PMS2, STK11, TP53
Pancreatitis panel (6 genes)	8022	CASR, CFTR, CPA1, PRSS1, SPINK1, CTRC
PGLNext® (14 genes)	5504	EGLN1, FH, KIF1B, MAX, MEN1, NF1, RET, SDHA, SDHAF2, SDHB, SDHC, SDHD, TMEM127, VHL
ProstateNext®^ (14 genes)	8845	ATM, BRCA1, BRCA2, CHEK2, EPCAM, HOXB13, MLH1, MSH2, MSH6, NBN, PALB2, PMS2, RAD51D, TP53
RenalNext® (20 genes)	5900	BAP1, CHEK2, EPCAM, FH, FLCN, MET, MIF, MLH1, MSH2, MSH6, PMS2, PTEN, SDHA, SDHB, SDHC, SDHD, TP53, TSC1, TSC2, VHL

Genes Eligible for +RNAinsight®: APC, ATM, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, MLH1, MSH2, MSH6, MUTYH, NF1, PALB2, PMS2 EX1-10, PTEN, RAD51C, RAD51D, TP53

^ AmbryScore for Breast is available as an add on to this panel if all of the following eligibility criteria are met:

- Female biological sex
- 18-84 years old
- Non-Ashkenazi Jewish, N. European ancestry
- No personal history of cancer (excluding non-melanoma skin cancer)
- No personal history of atypical hyperplasia or lobular carcinoma in situ (LCIS)
- No personal or family history of a mutation in a breast cancer susceptibility gene (ATM, BARD1, BLM [if tested], BRCA1, BRCA2, BRIP1, CDH1, CHEK2, FANCC [if tested], NBN, NF1, PALB2, PTEN, RAD51C, RAD51D, STK11, TP53)

Note: AmbryScore supplemental ordering form is required for processing

^^ AmbryScore for Prostate is available as an add on to this panel if all of the following eligibility criteria are met:

- Male biological sex
- 18-84 years old
- N. European ancestry
- No personal or family history of a mutation in a prostate cancer susceptibility gene (ATM, BRCA1, BRCA2, CHEK2, EPCAM, HOXB13, MLH1, MSH2, MSH6, NBN, PALB2, PMS2, RAD51D, TP53)

Note: No additional ordering forms are required for processing

† Limited evidence gene