Cancer Test Requisition Form (Abbreviated)

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

To submit an order via email, please send the completed test requisition form to info@ambrygen.com

1. SPECIMEN INFORMATION

Collection Date

☐ 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)	Sex at Birth ☐F ☐M	Date of Birth (MM/DD/YY)	MRN

Ethnicity: ☐ Asian ☐ Ashkenazi Jewish ☐ Black/African American ☐ White ☐ French Canadian/Cajun ☐ Hispanic/Latino ☐ Mediterranean ☐ Middle Eastern ☐ Native American ☐ Pacific Islander ☐ Portuguese ☐ Unknown ☐ Other:

Address	City	State	Zip

Phone	Email	Preferred Billing
		☐ Insurance ☐ Self-pay ☐ Institutional

3. ORDERING PROVIDER INFORMATION

Organization Name, Number	Address	City, State	Zip

Ordering Provider Name (Last, First), Ambry Number			
☐	☐	☐	☐
☐	☐	☐	☐

Genetic Counselor/Other Healthcare Professional Name (Last, First), Ambry Number		
☐	☐	☐

4. PERSONAL AND FAMILY HISTORY OF CANCER Attach clinic notes and/or pedigree

Personal History of Cancer: ☐ Yes ☐ No	Age of Dx:	Metastatic: ☐ Yes ☐ No	Tumor is ☐ MSI-High or ☐ IHC-Abnormal	ICD-10 Code(s)

Family History of Cancer: ☐ Yes ☐ No (if yes, please provide relative information below.) Patient Testing and Cancer Type Details:

Relationship to Patient	Mat	Pat	Age at Dx	Family Testing and Cancer Type Details	Reason relative has not been tested
	☐	☐			☐ Deceased ☐ Declines ☐ No Contact
	☐	☐			☐ Deceased ☐ Declines ☐ No Contact
	☐	☐			☐ Deceased ☐ Declines ☐ No Contact

5. TEST ORDERS

! REQUIRED: Select a Primary Test Order

For Patients Meeting *BRCA1/2* Testing Criteria

☐ *BRCA1/2* test

For Patients Meeting Colorectal Cancer Syndrome Testing Criteria (Lynch)

Lynch Syndrome test: ☐ *MLH1, MSH2, MSH6, PMS2, EPCAM*

For Patients Meeting Colorectal Cancer Syndrome Testing Criteria (polyposis)

Polyposis test: ☐ *APC/MUTYH*

☐ Other: _____

☐ None of the above (patient does not meet any genetic testing criteria)

Select an Optional Supplemental Test (Per payer policy, all tests in this section will be processed and billed separately; tests may be performed as a reflex.)

☐ BrainTumorNext® (8847)
☐ BRCAplus® (8836)
☐ BRCANext™ (8855)
☐ BRCANext-*Expanded*™ (8860)
☐ CancerNext® (8824)
☐ CancerNext-*Expanded*® (8874)
☐ ColoNext® (8822)
☐ CustomNext-*Cancer*® (9510)
Notes: _____
☐ MelanomaNext® (8849)
☐ PancNext® (8042)
☐ ProstateNext® (8845)
☐ Other: _____

Other Supplemental Test Options (Select if applicable)

☐ +RNAinsight® (Not available with BRCAplus or STAT orders; PAXgene® tube required for RNA)

Testing could aid in systemic therapy and/or surgical decision-making for my affected patient ☐ Yes ☐ No STAT TEST: ☐ Date results needed (if known): _____

Was genetic counseling completed? ☐ Yes ☐ No ☐ Unknown Date Genetic Counseling was Performed: _____

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 Ambry Genetics Corporation (Ambry), authorize Ambry 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 Ambry money received from my health insurance company.

We will start testing immediately and we will attempt to contact the patient if the estimated out-of-pocket costs are > USD $100.

For patient payment by credit card: I hereby authorize Ambry Genetics Corporation to bill my credit card as indicated above. In order to expedite consideration for eligibility for **Ambry'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 Ambry 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 Ambry 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 Ambry 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.

Ambry Genetics®

Patient Name: _____ DOB: _____

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, MITF, 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	*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, FAM175A(ABRAXAS1)ˆ, FANCC, FH, FLCN, GALNT12, GREM1, HOXB13, KIF1B, KIT, LZTR1, MAX, MEN1, MET, MITF, MLH1, MLH3ˆ, MRE11Aˆ, MSH2, MSH3, MSH6, MUTYH, NBN, NF1, NF2, NTHL1, PALB2, PALLDˆ, PDGFRA, PHOX2B, POT1, PMS2, POLD1, POLE, PRKAR1A, PRSS1, PTCH1, PTEN, RAD50ˆ, RAD51C, RAD51D, RB1, RECQL, RET, RINT1ˆ, RPS20ˆ, SDHA, SDHAF2, SDHB, SDHC, SDHD, SMAD4, SMARCA4, SMARCB1, SMARCE1, SPINK1, STK11, SUFU, TERTˆ, TMEM127, TP53, TSC1, TSC2, VHL, XRCC2* For Medicare Patients: At a minimum, the following core genes must be included in the panel to ensure Medicare coverage: *APC, ATM, BRCA1, BRCA2, CHEK2, EPCAM, MLH1, MSH2, MSH6, PALB2, PMS2, PTEN, TP53.*
HBOC	8838	*BRCA1, BRCA2*
Lynch syndrome/HNPCC	8517	*MLH1, MSH2, MSH6, PMS2 + EPCAM del/dup*
MelanomaNext® (9 genes)	8849	*BAP1, BRCA2, CDK4, CDKN2A, MITF, 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, MITF, MLH1, MSH2, MSH6, PMS2, PTEN, SDHA, SDHB, SDHC, SDHD, TP53, TSC1, TSC2, VHL*

ˆ Limited evidence gene