Ambry Genetics®

Cancer Test Requisition Form (Comprehensive)- Page 1 of 3

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

PLEASE SUBMIT THE FOLLOWING WITH THE TRF:

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

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

SPECIMEN INFORMATION (For phlebotomy service, select all services you are requesting)

Type(s): ☐ Blood (EDTA preferred) ☐ Saliva ☐ DNA ☐ Other: ☐ Personal history of allogenic bone marrow or peripheral stem cell transplant*

Collection Date	Specimen ID	Medical Record #

** 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*

Phlebotomy Services Request: ☐ Phlebotomy draw ☐ Send blood kit to patient** ☐ Send saliva kit to patient

*** As the patient's clinician, I am unaware of any potential for complication or difficulty in drawing blood for the listed patient(s). I understand that the phlebotomist has full authority to refuse to draw any patient if the safety of the phlebotomist and/or patient(s) are in question.*

ORDERING LICENSED PROVIDER/SENDING FACILITY (Each listed person will receive a copy of the report)

Facility Name (Facility Code)	Address	City	State /Country	Zip	Phone

Ordering Licensed Provider Name (Last, First)(Code)	NPI#	Phone	Fax/Email

Additional Results Recipients

Genetic Counselor or Other Medical Provider Name (Last, First) (Code)	Phone/Fax/Email

Genetic Counselor or Other Medical Provider Name (Last, First) (Code)	Phone/Fax/Email

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.

Signature Required for Processing 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 (if not self)	
Insurance Company	Policy #	HMO Auth #

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

Special Billing Notes:

☐ INSTITUTIONAL BILLING

Facility Name ☐ *Send invoice to facility address above*

Address

Contact Name

Phone Number	E-mail/Fax

☐ PATIENT PAYMENT

☐ Check (Payable to Ambry Genetics) ☐ Credit Card (Call 949-900-5795)

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.
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".

Signature Required For Insurance/Self-Pay Patients and NY Sample Storage Consent: Date:

Ambry Genetics®

Patient Name: _____ DOB: _____

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INDICATIONS FOR TESTING (Check all that apply)

ICD-10 code(s): _____

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 CLINICAL HISTORY

☐ No personal history of cancer

Cancer/Tumor	Age at Dx	Pathology and Other Info
Brain tumor		
Breast		Type: ER☐(+) ☐(-) ☐unk PR☐(+) ☐(-) ☐unk HER2/neu☐(+) ☐(-) ☐unk Metastatic:☐Y ☐N
2nd primary breast		Type: ER☐(+) ☐(-) ☐unk PR☐(+) ☐(-) ☐unk HER2/neu☐(+) ☐(-) ☐unk Metastatic:☐Y ☐N
Colorectal		Location:
Melanoma		
Ovarian		☐ Fallopian tube ☐ Primary peritoneal
Pancreatic		
Prostate		Gleason Score: Metastatic: ☐Y ☐N
Uterine		
Hematologic		Type: ☐Allogenic bone marrow or peripheral stem cell transplant^
Other Cancer		Type:
GI polyps		☐Adenomatous Polyp #:☐1 ☐2-5 ☐6-9 ☐10-19 ☐20-99 ☐100+ ☐Other type: Polyp #:☐1 ☐2-5 ☐6-9 ☐10-19 ☐20-99 ☐100+

Other clinical history:

^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

PATIENT TESTING HISTORY (Please include copies of any previous test results)

☐ No previous molecular and/or genetic testing

☐ Germline genetic testing Test(s) performed:_____

Result (s):_____

☐ Somatic test/tumor profile Test(s) performed:_____

Result(s): _____

☐ Microsatellite instability analysis:

☐ Stable (MSS) ☐ Unstable/high (MSI-H) ☐ Unstable/low (MSI-L)

☐ IHC, if multiple primaries, tumor used:_____

☐ Proteins present: _____ ☐ Proteins absent: _____

FAMILY HISTORY

Completing this section is not mandatory for ordering if a pedigree and/or clinical note with family history is supplied, but is recommended and helps with results interpretation and claims filing.

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

Relationship to Patient	Maternal	Paternal	Age at Each Dx	Family Testing and Cancer Type Details	If Relative Has Not Been Tested, Why? (select option)
	☐	☐		Cancer type(s): Pathology Details: Testing Details:	☐Deceased ☐Declines Testing ☐No Contact
	☐	☐		Cancer type(s): Pathology Details: Testing Details:	☐Deceased ☐Declines Testing ☐No Contact
	☐	☐		Cancer type(s): Pathology Details: Testing Details:	☐Deceased ☐Declines Testing ☐No Contact
	☐	☐		Cancer type(s): Pathology Details: Testing Details:	☐Deceased ☐Declines Testing ☐No Contact

Ambry Genetics®

Patient Name: _____ DOB: _____

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For multiple tests, testing will be run concurrently (initiated at the same time) unless otherwise specified. For reflexive testing (second test starts pending first test outcome), indicate the order of reflexive tests in the notes section or next to the test check box. For reflex test orders, any positive findings (pathogenic/likely pathogenic) in the first test will be reported, and the second test will be cancelled; all other findings will automatically reflex (including VUS).

CANCER 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)

Other Supplemental Test Options (Select if applicable)

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

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	29 gene brain tumor test
☐	BRCANext™	8855	18 gene breast cancer test
☐	BRCANext-*Expanded*™	8860	23 gene breast cancer test
☐	BRCAplus®	8836	8 gene breast cancer test
☐	CancerNext®	8824	36 gene cancer test
☐	CancerNext-*Expanded*®	8874	77 gene cancer test
☐	ColoNext®	8822	20 gene colorectal cancer test
☐	CustomNext-*Cancer*® Notes: _____ _____ _____	9510	up to 91 gene custom testˆˆ
☐	MelanomaNext®	8849	9 gene melanoma test
☐	PancNext®	8042	13 gene pancreatic cancer test
☐	Pancreatitis panel	8022	6 gene pancreatitis test
☐	PGLNext®	5504	14 gene PGL/PCC test
☐	ProstateNext®	8845	14 gene prostate cancer test
☐	RenalNext®	5900	20 gene renal cancer test

Order	Test Name	Test Code	Description
Hereditary Breast and/or Ovarian Cancer			
☐	*ATM*	9014	Ataxia-telangiectasia
☐	*BRCA1/2*	8838	Hereditary breast and ovarian cancer
☐	*BRCA1/2* Ashkenazi Jewish 3-site mutation panel	5892	
☐	*CHEK2*	9016	
☐	*DICER1*	5260	
☐	*PALB2*	2366	
☐	*PTEN*	2106	*PTEN*-related disorders (including Cowden syndrome)
☐	*TP53*	2866	Li-Fraumeni syndrome
Gastrointestinal Cancer			
☐	*APC*	3040	Familial adenomatous polyposis
☐	*APC* and *MUTYH*	8726	Adenomatous polyposis
☐	*BMPR1A* and *SMAD4*	8604	Juvenile polyposis syndrome
☐	*CDH1*	4726	Hereditary diffuse gastric cancer
☐	*EPCAM* del/dup	8519	Lynch syndrome
☐	Lynch syndrome	8517	*MLH1, MSH2, MSH6, PMS2 + EPCAM* del/dup
☐	*MLH1*	8508	Lynch syndrome
☐	*MSH2 + EPCAM* del/dup	8510	Includes *MSH2* inversion
☐	*MSH2* inversion	2226	Lynch syndrome
☐	*MSH6*	8512	Lynch syndrome
☐	*MUTYH*	4661	*MUTYH*-associated polyposis
☐	*PMS2*	4646	Lynch syndrome
☐	*STK11*	2766	Peutz-Jeghers syndrome

Order	Test Name	Test Code	Description
Genitourinary Cancer			
☐	*BAP1*	9044	
☐	*FH*	6301	Hereditary leiomyomatosis and renal cell cancer
☐	*FLCN*	5921	Birt-Hogg-Dubé syndrome
☐	*VHL*	2606	Von-Hippel Lindau disease
☐	*TSC1* and *TSC2*	5904	Tuberous sclerosis complex
Endocrine Tumors			
☐	*MEN1*	2646	Multiple endocrine neoplasia type 1
☐	*RET* gene sequence	2680	Multiple endocrine neoplasia type 2
Skin Cancer/Melanoma			
☐	*CDKN2A* and *CDK4* concurrent	4708	Familial atypical multiple mole melanoma (FAMMM)
☐	*PTCH1*	5684	Gorlin syndrome
Other Hereditary Cancer Testing			
☐	*NF1*	5704	Neurofibromatosis type 1
☐	*NF2*	9024	Neurofibromatosis type 2
☐	*RB1*	5426	Hereditary retinoblastoma
☐	*SMARCB1*	7180	Schwannomatosis
Other Orders			
☐	Please visit ambrygen.com for a list of available tests. Test Code(s): _____ Gene/Test Name(s): _____		

SPECIFIC SITE ANALYSIS (Please include a copy of relative's report)

Gene(s): _____ Mutation(s): _____

Relative Name: _____

Relationship to Relative:_____Accession # (if tested at Ambry): _____

Positive control sample: ☐ will be provided ☐ already at Ambry ☐ not available

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)†, FANCC, FH, FLCN, GALNT12, GREM1, HOXB13, KIF1B, KIT, LZTR1, MAX, MEN1, MET, MITF, 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* 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*

† Limited evidence gene