

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

1. SPECIMEN INFORMATION (Please see ambrygen.com/specimen-requirements for details)

Collection Date (Required)
 If date of collection is not provided, three calendar days before specimen receipt will be used (for specimens stored longer than 30 days, the day of archive retrieval will be used as the date of service)

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 <input type="checkbox"/> F <input type="checkbox"/> M	Date of Birth (MM/DD/YY)	MRN
Ethnicity: <input type="checkbox"/> Asian <input type="checkbox"/> Ashkenazi Jewish <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> French Canadian/Cajun <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Mediterranean <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Native American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Portuguese <input type="checkbox"/> Unknown <input type="checkbox"/> Other:				
Address		City	State	Zip
Phone	Email		Preferred Billing <input type="checkbox"/> Insurance <input type="checkbox"/> Self-pay <input type="checkbox"/> Institutional	

3. ORDERING PROVIDER INFORMATION

Organization Name, Number	Address	City, State	Zip
Ordering Provider Name (Last, First), Ambry Number, NPI <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. PERSONAL AND FAMILY HISTORY OF CANCER Attach clinic notes and/or pedigree

Personal History of Cancer: <input type="checkbox"/> Yes <input type="checkbox"/> No	Age of Dx:	Metastatic: <input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor is <input type="checkbox"/> MSI-High or <input type="checkbox"/> IHC-Abnormal	ICD-10 Code(s)	
Testing could aid in systemic therapy and/or surgical decision-making for my affected patient <input type="checkbox"/> Yes <input type="checkbox"/> No			Abnormal IHC Result:		
Patient Cancer Type Details:				<input type="checkbox"/> TNBC	
Family History of Cancer: <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient Testing: <input type="checkbox"/> Yes <input type="checkbox"/> No	Details:			
Relationship to Patient	Mat	Pat	Age at Dx	Family Testing and Cancer Type Details	Reason relative has not been tested
	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Deceased <input type="checkbox"/> Declines <input type="checkbox"/> No Contact
	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Deceased <input type="checkbox"/> Declines <input type="checkbox"/> No Contact
	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Deceased <input type="checkbox"/> Declines <input type="checkbox"/> No Contact
	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Deceased <input type="checkbox"/> Declines <input type="checkbox"/> No Contact
	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Deceased <input type="checkbox"/> Declines <input type="checkbox"/> No Contact

5. TEST ORDERS

REQUIRED: Select a Primary Test Order	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.)
For Patients Meeting BRCA1/2 Testing Criteria <input type="checkbox"/> BRCA1/2 test	<input type="checkbox"/> BrainTumorNext® (8847) <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)
For Patients Meeting Colorectal Cancer Syndrome Testing Criteria (Lynch) Lynch Syndrome test: <input type="checkbox"/> MLH1, MSH2, MSH6, PMS2, EPCAM	<input type="checkbox"/> CustomNext-Cancer® (9510) Notes: _____ <input type="checkbox"/> MelanomaNext® (8849) <input type="checkbox"/> PancNext® (8042) <input type="checkbox"/> ProstateNext® (8845) <input type="checkbox"/> Other: _____
For Patients Meeting Colorectal Cancer Syndrome Testing Criteria (polyposis) Polyposis test: <input type="checkbox"/> APC/MUTYH <input type="checkbox"/> Other: _____ <input type="checkbox"/> None of the above (patient does not meet any genetic testing criteria)	Other Supplemental Test Options (Select if applicable) <input type="checkbox"/> +RNAinsight® (Not available with BRCAplus or STAT orders; PAXgene® tube required for RNA)

Collection Assistance: Phlebotomy draw Send saliva kit to patient

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.

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: By checking this box, I agree that Ambry Genetics will retain my sample for 6 months after the testing above has been completed. By not checking this box, I understand that under New York State law, Ambry Genetics must discard my sample after the longer of (a) testing completion and (b) 60 days after the Date of Collection above.

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.

Supplemental Information

Hereditary Cancer Multi-Gene Tests

Test Name	Test Code	Genes
Adenomatous polyposis	8726	<i>APC, MUTYH</i>
BrainTumorNext® (29 genes)	8847	<i>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</i>
BRCANext® (18 genes)	8855	<i>ATM, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, EPCAM, MLH1, MSH2, MSH6, NBN, NF1, PALB2, PMS2, PTEN, RAD51C, RAD51D, TP53</i>
BRCANext-Expanded® (23 genes)	8860	<i>ATM, BARD1, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, DICER1, EPCAM, MLH1, MSH2, MSH6, NBN, NF1, PALB2, PMS2, PTEN, RAD51C, RAD51D, RECQL, SMARCA4, STK11, TP53</i>
BRCPlus® (8 genes)	8836	<i>ATM, BRCA1, BRCA2, CDH1, CHEK2, PALB2, PTEN, TP53</i>
CancerNext® (36 genes)	8824	<i>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</i>
CancerNext-Expanded® (77 genes)	8874	<i>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</i>
ColoNext® (20 genes)	8822	<i>APC, AXIN2, BMPR1A, CDH1, CHEK2, EPCAM, GREM1, MLH1, MSH2, MSH3, MSH6, MUTYH, NTHL1, PMS2, POLD1, POLE, PTEN, SMAD4, STK11, TP53</i>
CustomNext-Cancer® (up to 91 genes) Required: complete CustomNext-Cancer supplemental form. ambrygen.com/forms	9510	<i>AIP, ALK, APC, ATM, AXIN2, BAP1, BARD1, BLM, BRCA1, BRCA2, BRIP1, BMPR1A, CASR, CDC73, CDH1, CDK4, CDKN1B, CDKN2A, CFTR, CHEK2, CPA1, CTNNA1, CTSC, DICER1, EGFR, EGLN1, EPCAM, FAM175A(ABRAXAS1)ˆ, FANCC, FH, FLCN, GALNT12, GREM1, HOXB13, KIF1B, KIT, LZTR1, MAX, MEN1, MET, MIF, 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</i> For Medicare Patients: At a minimum, the following core genes must be included in the panel to ensure Medicare coverage: <i>APC, ATM, BRCA1, BRCA2, CHEK2, EPCAM, MLH1, MSH2, MSH6, PALB2, PMS2, PTEN, TP53</i> .
HBOC	8838	<i>BRCA1, BRCA2</i>
Lynch syndrome/HNPCC	8517	<i>MLH1, MSH2, MSH6, PMS2 + EPCAM del/dup</i>
MelanomaNext® (9 genes)	8849	<i>BAP1, BRCA2, CDK4, CDKN2A, MIF, POT1, PTEN, RB1, TP53</i>
PancNext® (13 genes)	8042	<i>APC, ATM, BRCA1, BRCA2, CDKN2A, EPCAM, MLH1, MSH2, MSH6, PALB2, PMS2, STK11, TP53</i>
Pancreatitis panel (6 genes)	8022	<i>CASR, CFTR, CPA1, PRSS1, SPINK1, CTSC</i>
PGLNext® (14 genes)	5504	<i>EGLN1, FH, KIF1B, MAX, MEN1, NF1, RET, SDHA, SDHAF2, SDHB, SDHC, SDHD, TMEM127, VHL</i>
ProstateNext® (14 genes)	8845	<i>ATM, BRCA1, BRCA2, CHEK2, EPCAM, HOXB13, MLH1, MSH2, MSH6, NBN, PALB2, PMS2, RAD51D, TP53</i>
RenalNext® (20 genes)	5900	<i>BAP1, CHEK2, EPCAM, FH, FLCN, MET, MIF, MLH1, MSH2, MSH6, PMS2, PTEN, SDHA, SDHB, SDHC, SDHD, TP53, TSC1, TSC2, VHL</i>

ˆ Limited evidence gene

Specimen Requirements

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.