Ambry Genetics

Reproductive Health Test Requisition Form

Email Orders: Send form to info@ambrygen.com

1. PATIENT INFORMATION

Name (Last)	Name (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 _____ *See Carrier Screening Ethnicity section on page 2*

Address	City	State	Zip

Phone	Email

2. PROVIDER INFORMATION

Organization Name, Number	Address	City, State	Zip

Ordering Provider Name (Last, First), Ambry Number		NPI	Primary Contact(s)
☐	☐		☐
☐	☐	Phone Number	☐
☐	☐	Email/Fax	☐

CONFIRMATION OF INFORMED CONSENT AND MEDICAL NECESSITY FOR GENETIC TESTING:
According to clinical care recommendations for NIPT, informed decision-making should take place prior to the sample collection. Please refer to published standards for more information. 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 post-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.

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

3. BILLING INFORMATION (SELECT ONE)

☐ INSURANCE (Attach front and back of insurance card)

Insurance Name _____

Group # _____ Member ID # _____

Member Name _____

Prior Authorization Number (If applicable, please attach) _____

☐ INSTITUTIONAL

Facility Name _____

Contact Name _____

Address _____

Phone Number _____ Email/Fax _____

☐ PATIENT

☐ Check to Ambry Genetics
☐ Credit Card (Ambry will contact patient for payment)

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.

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

4. PREGNANCY INFORMATION & test selection

! **REQUIRED: Complete Section**

Pregnant? ☐Yes ☐No **First Pregnancy?** ☐Yes ☐No **Preconception planning?** ☐Yes ☐No

Pregnancy type[1]: ☐Singleton ☐Twin ☐Unknown **Maternal BMI** _____

Estimated Delivery Date (EDD) (MM/DD/YYYY) _____ ☐ US ☐ LMP

Pregnancy conceived by reproductive technology? ☐Yes ☐ No

Was an egg donor used? ☐Yes ☐No If Yes, age of egg donor _____

Has pre-test counseling been performed? ☐Yes ☐No

Was the pre-test counseling performed by a board-certified or board-eligible genetic specialist? (i.e genetic counselor, nurse, etc.) ☐Yes ☐No

[1] Screening cannot be performed for higher order multiples

NIPT (NON-INVASIVE PRENATAL SCREENING)

Use: (One) Blood 10mL STRECK Tiger Top (cfDNA)

! REQUIRED: Select Core Test
☐ Chromosomes 21, 18, 13 (9080, 9081)

Add-On Test
☐ Sex Chromosomes[2] (includes fetal sex)
☐ All Chromosomes[3] (singleton only; includes fetal sex)
☐ Microdeletions[3] (singleton only)

Collection Date (Required)
_____/_____/_____
(Minimum 10 weeks gestational age)
Collection date is required for testing to proceed. Failure to provide may result in delays and/or test cancellation.

Phlebotomy: ☐Yes, service required

Clinical Indications ***Required. See supplementary ICD-10 guide on page 2.***

☐ICD-10 Codes: _____

Relevant Ultrasound Findings: _____

Relevant Family History: _____

[2] Twin sex chromosome analysis consists only of presence or absence of Y chromosome.
[3] Microdeletion and all chromosome analysis are not available for twin gestations.

CARRIER SCREENING

Use: (One) Blood 4mL EDTA Purple Top or Saliva (OG-500)

! REQUIRED: Select Core Test
☐ CF + SMA (*SMN1*) (9082)
☐ Ashkenazi Jewish (9083) (includes CF + SMA)

Add-On Test
☐ Guidelines-Based[4] (9085-A)
☐ Comprehensive[4] (9086-A)
☐ Fragile X[4,5] (9084-A)

Collection Date (Required)
_____/_____/_____
Collection date is required for testing to proceed. Failure to provide may result in delays and/or test cancellation.

Phlebotomy: ☐Yes, service required

Saliva Kit: ☐Send kit to patient

Clinical Indications ***Required. See supplementary ICD-10 guide on page 2.***

☐ICD-10 Codes: _____

Partner testing done at Ambry?: ☐Yes ☐No Ambry ID_____
Partner Name (First, Last)_____ DOB (mm/dd/yyyy) _____

By providing the partner's information, I certify that I am the ordering provider / practice member for both partners. I have obtained each partner's consent to share their results and both parties will have access to each other's test results.

[4] Males are not tested for X-linked disorders
[5] Automatic reflex to AGG analysis in carrier patients who have a premutation with 55-90 CGG repeats

Ambry Genetics®

Sample Requirements & Related ICD-10 Codes

NIPT

Sample

One 10mL Streck tiger top cell-Free DNA BCT® blood tube

Note: Patients must be at least 10 weeks gestation.

Test Options

Chromosomes 21, 18, 13

- Sex Chromosomes[2] (includes fetal sex)
- All Chromosomes[3] (singleton only, includes fetal sex)
- Microdeletions (singleton only)

[2] Twin sex chromosome analysis consists only of presence or absence of Y chromosome.

[3] Microdeletions and All Chromosomes are not available for twin pregnancies

Review test specifications at
https://www.ambrygen.com/providers/specimen-requirements

General Screening

Encounter for other genetic testing of female for procreative management	Z31.438
Encounter for supervision of normal first pregnancy, unspecified trimester	Z34.00
Encounter for supervision of normal first pregnancy, 1st trimester	Z34.01
Encounter for supervision of normal first pregnancy, 2nd trimester	Z34.02
Encounter for supervision of normal first pregnancy, 3rd trimester	Z34.03
Encounter for supervision of other normal pregnancy, unspecified trimester	Z34.80
Encounter for supervision of other normal pregnancy, 1st trimester	Z34.81
Encounter for supervision of other normal pregnancy, 2nd trimester	Z34.82
Encounter for supervision of other normal pregnancy, 3rd trimester	Z34.83

Increased Risk

Supervision of elderly primigravida, 1st trimester	O09.511
Supervision of elderly primigravida, 2nd trimester	O09.512
Supervision of elderly primigravida, 3rd trimester	O09.513
Supervision of elderly primigravida, unspecified trimester	O09.519
Supervision of elderly multigravida, 1st trimester	O09.521
Supervision of elderly multigravida, 2nd trimester	O09.522
Supervision of elderly multigravida, 3rd trimester	O09.523
Supervision of elderly multigravida, unspecified trimester	O09.529
Supervision of other high risk pregnancies, 1st trimester	O09.891
Supervision of other high risk pregnancies, 2nd trimester	O09.892
Supervision of other high risk pregnancies, 3rd trimester	O09.893
Supervision of other high risk pregnancies, unspecified trimester	O09.899
Pregnancy care for patient with recurrent pregnancy loss, unspecified trimester	O26.20
Pregnancy care for patient with recurrent pregnancy loss, 1st trimester	O26.21
Pregnancy care for patient with recurrent pregnancy loss, 2nd trimester	O26.22
Pregnancy care for patient with recurrent pregnancy loss, 3rd trimester	O26.23

Abnormal Findings

Abnormal hematological finding on antenatal screening of mother	O28.0
Abnormal biochemical finding on antenatal screening of mother	O28.1
Abnormal radiological finding on antenatal screening of mother	O28.4
Abnormal chromosomal and genetic finding on antenatal screening of mother	O28.8
Abnormal chromosomal and genetic finding on antenatal screening of mother	O28.5
Other abnormal findings on antenatal screening of mother	O28.8
Unspecified abnormal findings on antenatal screening of mother	O28.9
Abnormal ultrasonic finding on antenatal screening of mother	O28.3
Abnormal chromosomal and genetic finding on antenatal screening of mother	O28.5
Maternal care for (suspected) chromosomal abnormality in fetus, unspecified	O35.10X0
Maternal care for (suspected) chromosomal abnormality in fetus, unspecified	O35.1XX0
Encounter for antenatal screening for chromosomal anomalies	Z36.0
Maternal care for (suspected) hereditary disease in fetus, unspecified	O35.2XX0
Encounter for antenatal screening for raised alphafetoprotein level	Z36.1
Encounter for other antenatal screening follow-up	Z36.2
Encounter for other antenatal screening for malformations	Z36.3
Encounter for antenatal screening for fetal growth retardation	Z36.4
Encounter for antenatal screening for hydrops fetalis	Z36.81
Encounter for antenatal screening for nuchal translucency	Z36.82
Encounter for fetal screening for congenital cardiac abnormalities	Z36.83

Carrier Screening

Sample

One 4mL purple top EDTA tube

-OR-

One 2mL Oragene® saliva tube

Panels & Genes

CF+SMA (Cystic Fibrosis+Spinal Muscular Atrophy): 2 genes

Ashkenazi Jewish: 48 genes

Guidelines-Based: 163 genes

Comprehensive: 419 genes

Fragile X: 1 gene

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https://www.ambrygen.com/providers/specimen-requirements

General Screening

Encounter for nonproductive screening for genetic disease carrier status	Z13.71
Encounter for screening for other specified diseases and disorders	Z13.8
Screening for other disorder	Z13.8
Cystic fibrosis carrier	Z14.1
Genetic carrier of other disease	Z14.8
Encounter of female for testing for genetic disease carrier status	Z31.430
Encounter of male for testing for genetic disease carrier status	Z31.440
Encounter for procreative genetic counseling	Z31.5
Encounter for supervision of normal first pregnancy, unspecified trimester	Z34.00
Encounter for supervision of normal first pregnancy, 1st trimester	Z34.01
Encounter for supervision of normal first pregnancy, 2nd trimester	Z34.02
Encounter for supervision of normal first pregnancy, 3rd trimester	Z34.03
Encounter for supervision of other normal pregnancy, unspecified trimester	Z34.80
Encounter for supervision of other normal pregnancy, 1st trimester	Z34.81
Encounter for supervision of other normal pregnancy, 2nd trimester	Z34.82
Encounter for supervision of other normal pregnancy, 3rd trimester	Z34.83
Encounter for antenatal screening for chromosomal anomalies	Z36.0
Encounter for antenatal screening for other genetic defects	Z36.8A
Encounter for genetic counseling	Z31.5

Family History

Family history of intellectual disabilities	Z81.0
Family history of other diseases of the musculoskeletal system and connective tissue	Z82.69
Family history of other congenital malformations, deformations and chromosomal abnormalities	Z82.79
Family history of carrier of genetic disease	Z84.81
Family history of other specified conditions	Z84.89

Carrier Screening Ethnicity

The following ethnicities can be written into the "Other" box on the front of this form under Patient Information. Specific patient ancestry may help with results for Carrier Screening.

Note: Insurance reimbursement for Ashkenazi Jewish panels is typically dependent on stated AJ ethnicity.

- East Asian (China, Japan, Korea)
- Finnish
- French Canadian
- Mennonite
- Northern European (Scandinavian, UK, Germany)
- Sephardic Jewish
- South Asian (India, Pakistan)
- Southeast Asian (Vietnam, Cambodia, Thailand)
- Southern European (Spain, Italy, Greece)

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