Ambry Genetics®
A TEMPUS COMPANY

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

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

PATIENT INFORMATION

Legal Name (Last, First, MI)	Date of Birth (MM/DD/YY)	Sex Assigned at Birth ☐F ☐M	Gender (optional) ☐Man ☐Woman ☐Nonbinary ☐Self-described

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

MRN

Address	City	State	Zip

Mobile #	Email

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

☐ Personal history of allogenic bone marrow or peripheral stem cell transplant

Specimen ID	Medical Record #

Collection Assistance: ☐Phlebotomy draw* ☐Send saliva kit to patient ☐Send buccal swab 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

I confirm that the genetic test ordered is medically appropriate. All information on this TRF is true to the best of my knowledge. I also confirm that the patient has consented to proceed with genetic testing, including the transfer and processing of their sample and personal/sensitive information in the United States. 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.

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 #

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.

☐ I agree to be contacted regarding future research studies for which I may be a candidate. Any future research projects will be subject to a separate informed consent process and participation is voluntary. Learn more about Ambry's privacy practices at https://www.ambrygen.com/legal/notice-of-privacy-practices.

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 understand that New York State law requires Ambry Genetics to destroy my sample at the end of the testing process or not more than sixty days after the sample was taken. By checking this box, I agree that Ambry Genetics will instead retain my sample for at least 6 months after the testing above has been completed, and may (a) retain and use samples and health information for an indefinite period of time in accordance with applicable law; and (b) de-identify such samples and information and use and share the resulting de-identified samples and information in accordance with applicable law.

Patient Signature (I agree to terms above): Date:

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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 ☐ My patient is the most informative family member available for testing. The affected relative and all intervening relatives are either deceased or unwilling/unavailable for 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:

Known Familial Variant: ☐ Family ☐ Self Gene: _____ Variant (c. and/or p.): _____ Testing Lab: _____ Ambry ID: _____

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

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Patient Name: _____ DOB: _____

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Concurrent Testing: There is no action needed on your part if this is your desired strategy.
☐ **Reflex Testing:** Please select this option if you wish to have testing performed in a reflex manner, and indicate the order of testing below:
Test 1: _____ Test 2: _____
See Reflex or Concurrent Testing section of the Supplemental Information page for more information.

CANCER TEST ORDERS

Primary Test Order

! **REQUIRED: Select a Primary Test Order**

For Patients Meeting *BRCA1/2* Testing Criteria	For Patients Meeting Colorectal Cancer Syndrome Testing Criteria (polyposis)
☐ *BRCA1/2* test	Polyposis test: ☐ *APC/MUTYH*
For Patients Meeting Colorectal Cancer Syndrome Testing Criteria (Lynch)	☐ Other: _____
Lynch Syndrome test: ☐ *MLH1, MSH2, MSH6, PMS2, EPCAM*	☐ 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.)

Order	Test Code	Test Name	Description
☐	8857	BRCANext®	19 gene breast & gynecologic cancer test
		Add on: ☐ Limited Evidence (Additional 7 genes)	
☐	8836	BRCAPlus®	13 gene STAT breast management test
☐	8824	CancerNext®	40 gene pan-cancer test
☐	8875	CancerNext-*Expanded*®	77 gene pan-cancer test
		Add on: ☐ Limited Evidence (Additional 8 genes)	
		Add on: ☐ Pancreatitis (Additional 5 genes)	

Order	Test Code	Test Name	Description
☐	8821	ColoNext®	21 gene colorectal cancer & polyposis test
		Add on: ☐ Limited Evidence (Additional 5 genes)	
☐	9511	CustomNext-*Cancer*® Notes: _____ _____ _____	up to 90 gene custom test Gene content is required. Use CustomNext-*Cancer* supplemental form for guidance.

Other Supplemental Test Options (Select if applicable)

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

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

Order	Test Code	Test Name	Description
Genitourinary Cancer			
☐	9044	*BAP1*	
☐	6301	*FH*	Hereditary leiomyomatosis and renal cell cancer
☐	5921	*FLCN*	Birt-Hogg-Dubé syndrome
☐	2606	*VHL*	Von-Hippel Lindau disease
☐	5904	*TSC1* and *TSC2*	Tuberous sclerosis complex
Endocrine Tumors			
☐	2646	*MEN1*	Multiple endocrine neoplasia type 1
☐	2680	*RET* gene sequence	Multiple endocrine neoplasia type 2
Skin Cancer/Melanoma			
☐	4708	*CDKN2A* and *CDK4* concurrent	Familial atypical multiple mole melanoma (FAMMM)
☐	5684	*PTCH1*	Gorlin syndrome
Other Hereditary Cancer Testing			
☐	5704	*NF1*	Neurofibromatosis type 1
☐	9024	*NF2*	Neurofibromatosis type 2
☐	5426	*RB1*	Hereditary retinoblastoma
☐	7180	*SMARCB1*	Schwannomatosis
☐	8022	*CASR, CFTR, CPA1, PRSS1, SPINK1, CTRC*	Pancreatitis panel
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

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Patient Name: _____ DOB: _____

Supplemental Information

Hereditary Cancer Multi-Gene Tests

TEST NAME	TEST CODE	GENES
Pan-cancer		
CancerNext® (40 genes)	8824	*APC, ATM, AXIN2, BAP1, BARD1, BMPR1A, BRCA1, BRCA2, BRIP1, CDH1, CDKN2A, CHEK2, EPCAM, FH, FLCN, GREM1, HOXB13, MBD4, MET, MLH1, MSH2, MSH3, MSH6, MUTYH, NF1, NTHL1, PALB2, PMS2, POLD1, POLE, PTEN, RAD51C, RAD51D, RPS20, SMAD4, STK11, TP53, TSC1, TSC2, VHL*
CancerNext-*Expanded*® (77 genes or up to 90 genes w/ add-ons)	8875	*AIP, ALK, APC, ATM, AXIN2, BAP1, BARD1, BMPR1A, BRCA1, BRCA2, BRIP1, CDC73, CDH1, CDK4, CDKN1B, CDKN2A, CEBPA, CHEK2, CTNNA1, DDX41, DICER1, EGFR, EPCAM, ETV6, FH, FLCN, GATA2, GREM1, HOXB13, KIT, LZTR1, MAX, MBD4, MEN1, MET, MITF, MLH1, MSH2, MSH3, MSH6, MUTYH, NF1, NF2, NTHL1, PALB2, PDGFRA, PHOX2B, PMS2, POLD1, POLE, POT1, PRKAR1A, PTCH1, PTEN, RAD51C, RAD51D, RB1, RET, RPS20, RUNX1, SDHA, SDHAF2, SDHB, SDHC, SDHD, SMAD4, SMARCA4, SMARCB1, SMARCE1, STK11, SUFU, TMEM127, TP53, TSC1, TSC2, VHL, WT1* Optional Add-on 1 - Limited Evidence Genes (8 genes): *ATRIP, EGLN1, KIF1B, MLH3, PALLD, RAD51B, RNF43, TERT* Optional Add-on 2 - Pancreatitis Genes (5 genes): *CFTR, CPA1, CTRC, PRSS1, SPINK1*
STAT Breast Management		
BRCAPlus® (13 genes)	8836	*ATM, BARD1, BRCA1, BRCA2, CDH1, CHEK2, NF1, PALB2, PTEN, RAD51C, RAD51D, STK11, TP53*
Breast & gynecologic		
BRCANext® (19 genes or up to 26 genes w/ add-on)	8857	*ATM, BARD1, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, EPCAM, MLH1, MSH2, MSH6, NF1, PALB2, PMS2, PTEN, RAD51C, RAD51D, STK11, TP53* Optional Add-on - Limited Evidence Genes (7 genes): *ATRIP, CDC73, FH, NTHL1, POLD1, POLE, RAD51B*
Colorectal & polyposis		
ColoNext® (21 genes or up to 26 genes w/ add-on)	8821	*APC, AXIN2, BMPR1A, CDH1, EPCAM, GREM1, MBD4, MLH1, MSH2, MSH3, MSH6, MUTYH, NTHL1, PMS2, POLD1, POLE, PTEN, RPS20, SMAD4, STK11, TP53* Optional Add-on - Limited Evidence Genes (5 genes): *ATM, CHEK2, CTNNA1, MLH3, RNF43*
Customizable		
CustomNext-*Cancer*® (up to 90 genes) Required: complete CustomNext-*Cancer* supplemental form. ambrygen.com/forms	9511	To order all genes on Ambry's oncology menu, please order CancerNext-*Expanded*. *AIP, ALK, APC, ATM, ATRIP, AXIN2, BAP1, BARD1, BMPR1A, BRCA1, BRCA2, BRIP1, CDC73, CDH1, CDK4, CDKN1B, CDKN2A, CEBPA, CFTR, CHEK2, CPA1, CTNNA1, CTRC, DICER1, DDX41, EGFR, ELGN1, EPCAM, ETV6, FH, FLCN, GATA2, GREM1, HOXB13, KIF1B, KIT, LZTR1, MAX, MBD4, MEN1, MET, MITF, MLH1, MLH3, MSH2, MSH3, MSH6, MUTYH, NF1, NF2, NTHL1, PALB2, PALLD, PDGFRA, PHOX2B, PMS2, POLD1, POLE, POT1, PRKAR1A, PRSS1, PTCH1, PTEN, RAD51B, RAD51C, RAD51D, RB1, RET, RNF43, RPS20, RUNX1, SDHA, SDHAF2, SDHB, SDHC, SDHD, SMAD4, SMARCA4, SMARCB1, SMARCE1, SPINK1, STK11, SUFU, TERT, TMEM127, TP53, TSC1, TSC2, VHL, WT1* 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.*
Syndrome specific		
Adenomatous polyposis	8726	*APC, MUTYH*
BRCA1/2-associated hereditary breast and ovarian cancer (HBOC)	8838	*BRCA1, BRCA2*
Lynch syndrome	8517	*MLH1, MSH2, MSH6, PMS2 + EPCAM del/dup*

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Patient Name: _____ DOB: _____

Supplemental Information

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.

Buccal swab samples from patients with a history of allogenic bone marrow or stem cell transplant should not be used for genetic testing. For these patients, an alternative specimen (e.g. cultured fibroblasts) is required. Testing on buccal swab samples from patients with active hematological disease is not recommended. An alternative specimen (e.g. cultured fibroblasts) is recommended. Please see ambrygen.com/specimen-requirements for details.

Specific site analysis for variants identified at an external laboratory must be accompanied by a copy of the original testing report. A positive control from a known positive family member is recommended (required for prenatal testing).

Reflex or Concurrent Testing

Concurrent testing is when multiple tests are initiated at the same time. When multiple tests are ordered on the same test requisition form, testing will be run concurrently unless otherwise specified.

Reflex testing is when a subsequent test is initiated pending the outcome of the initial test. Reflex testing may result in delayed reporting of results.

For reflex test orders:

- Any diagnostic finding at any step will result in cancellation of any subsequent reflex tests.
- Non-diagnostic findings (including VUS or Uncertain results) will automatically reflex to the subsequent test.
- Secondary findings results do not impact whether a subsequent test is initiated or canceled.

When ordering STAT panels (such as BRCAplus®), the results of the STAT panel will be prioritized and reported with a shorter turnaround time, even if the tests were run concurrently.

Known Familial Variants

Variant-specific report comments about the presence or absence of known familial variant(s) require the "Known Familial Variant" section of this form to be completed accurately, including an internal Ambry reference ID and/or a copy of the positive family member's lab report. Acceptable types of Ambry identifiers include:

- Accession number
- Order number
- Name and date of birth

Variant requests without an internal Ambry reference ID or positive family member's lab report will not receive a variant-specific report comment.

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