

CLIENT INFORMATION

ORDERING PHYSICIAN	NPI #
TREATING PHYSICIAN	NPI #
PHYSICIAN/AUTHORIZED SIGNATURE	

PATIENT INFORMATION

Name (LAST, FIRST, MIDDLE): _____

Date of Birth: _____ Sex: Male Female

Address: _____

City, State, Zip: _____

Phone Number: _____ MRN / PT ID#: _____

BILLING INFORMATION (face sheet & front and back of insurance card must be attached)

Bill: My Account Insurance Medicare Medicaid Patient Workers Comp See attached

Patient Hospital Status: InPatient OutPatient Non-Patient

Insured Information: Name _____

Relationship to Patient (circle one) Self Spouse Child Other: _____

Primary Insurance Co: _____ Authorization # _____

Billing Address _____ Insured # _____

Billing City, State, Zip _____ Group # _____

SPECIMEN INFORMATION

Collection Date: _____ Time: _____ AM PM

Specimen Type: Peripheral Blood Specimen ID #: _____

PATIENT CLINICAL CANCER HISTORY

No personal history of cancer

Breast: Invasive or DCIS, age at Dx _____
(Check all that apply) Bilateral Premenopausal Triple Negative (ER-, PR-, HER-)

Ovarian: Age at Dx _____ Endometrial: Age at Dx _____

Prostate: Age at Dx _____ If Prostate, Gleason score: _____

Pancreatic: Age at Dx _____ Renal: Age at Dx _____

Endocrine: Age at Dx _____ Type: Thyroid Pheochromocytoma Paranglioma

Colorectal: Age at Dx _____

MSI Testing Done: Yes No MSI Result: High Stable Low

IHC Testing Done: Yes No IHC Result: Present Absent IHC of _____

MLH1 Methylation status: Not done Methylated tumor only
 Methylated tumor and normal tissue Unmethylated

BRAF V600E: Not Done Present Absent

Colon Polyps: Age of first polyp _____ If Adenomatous, total # _____

Other Cancers: Type _____ Age(s) of Dx: _____

History of Bone Marrow Transplant: Yes No If yes, please contact us at 800-345-4363 prior to sample collection.

CLINICAL INDICATION FOR STUDY (attach previous test results if applicable)

Narrative Diagnosis: _____

All Diagnoses should be provided by the ordering physician or an authorized designee.
Diagnosis/Signs/Symptoms in ICD-CM format in effect at Date of Service (Highest Specificity Required)

ICD-CM	ICD-CM	ICD-CM
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Genetic Counseling Provided: Yes No Counselor name: _____

Institution: _____ Phone #: _____

Note: Some insurance companies require genetic counseling before approving BRCAsure and VistaSeq testing. If you are unsure, please contact us at 855-488-8750.

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Patient, client, and billing information is requested for timely processing of this case. Medicare and other third party payors require that services be medically necessary for coverage, and generally do not cover routine screening tests

Symbols Legend
= Medicare deems investigational. Medicare does not pay for services it deems investigational.

Refer to Determining Necessity of ABN Completion on reverse.

SPECIMEN LABEL INSTRUCTIONS

1. Complete the requisition with all requested information.
2. Label specimen with two unique identifiers.
3. Remove the required number of labels from the front of this sheet.
4. Place one (1) label on each specimen container (not on the lid).
Please dispose of unused labels.

TEST REQUEST

▲ Please attach a copy of family member's test results

HEREDITARY CANCER PANEL (see reverse for gene list)

VistaSeq® Hereditary Cancer Panel (27 Gene Assay) (481220)

VistaSeq® Hereditary Cancer Panel Minus BRCA1/2 genes (25 Gene Assay) (481240)

VistaSeq® Breast Cancer Panel (19 Gene Assay) (481319)

VistaSeq® High/Moderate Risk Breast Cancer Panel (9 Gene Assay) (481452)

VistaSeq® GYN Cancer Panel (11 Gene Assay) (481330)

VistaSeq® Breast and GYN Cancer Panel (25 Gene Assay) (481341)

VistaSeq® High Risk Colorectal Cancer Panel (7 Gene Assay) (481352)

VistaSeq® Colorectal Cancer Panel (22 Gene Assay) (481363)

VistaSeq® Brain/CNS/PNS Cancer Panel (17 Gene Assay) (481386)

VistaSeq® Endocrine Cancer Panel (13 Gene Assay) (481374)

VistaSeq® Pancreatic Cancer Panel (14 Gene Assay) (481385)

VistaSeq® Renal Cell Cancer Panel (19 Gene Assay) (481407)

HEREDITARY BREAST AND OVARIAN CANCER (test components on back)

BRCAsure® Comprehensive Analysis* (252911)

BRCAsure® BRCA1 Targeted Analysis▲ (252235)

BRCAsure® BRCA2 Targeted Analysis▲ (252250)

BRCAsure® Ashkenazi Jewish Panel (252970)

BRCAsure® BRCA1/2 Deletion/Duplication Analysis (252888)

LYNCH SYNDROME GERMLINE TESTING

Panels

MLH1/MSH2 Comprehensive Analysis* (511660)

MLH1/MSH2/MSH6 Comprehensive Analysis* (511673)

MLH1/MSH2/MSH6/PMS2 Comprehensive Analysis* (511700)

Individual Tests: _____
See reverse side for individual test list and write in test name/test code in the space above

Mutation Specific Sequencing (451382)
Required: Gene(s): _____
Mutation(s): _____

PREVIOUS GENETIC TESTING FOR CANCER

Has the patient had genetic testing for cancer? If yes, please document the gene(s) tested and results: _____

FAMILY HISTORY

▲ Please attach a copy of family member's test results

Is there a family history of cancer? Yes No Unknown

Other family members tested positive for a hereditary cancer syndrome? Yes No
Type ▲: _____

Is the patient adopted? Yes No Unknown

Does the patient have Ashkenazi Jewish Ancestry? Yes No

Please attach pedigree or complete table below. Is a pedigree attached? Yes No

Relationship (Father, Sister, Aunt, etc.)	Maternal or Paternal Please indicate	Relative Available for Testing? If no, please state reason	Known Mutation? If yes, please attach lab report	Cancer Type	Age at Diagnosis

Patient understands by signing below:

LabCorp may use information obtained on this form and other information provided by me and/or my ordering provider or his/her designee to initiate preauthorization with my health plan as required. I understand a preauthorization approval from my health plan does not guarantee full payment.

LabCorp will make 3 attempts to contact me if my estimated out-of-pocket payment is more than \$300. If a sample has been received, testing may be canceled if LabCorp is unable to reach me. No matter my estimated payment amount, my actual out-of-pocket expense may be higher or lower than the estimate LabCorp may provide. It is my responsibility to contact my insurance company regarding concerns over my coverage and benefits.

Patient's Signature (required) _____

Patient Phone Number: _____

Prior-authorization form has been sent separately. Please contact Prior Authorization at 855-488-8750 if you have any questions about our service.

INFORMED CONSENT

I have obtained informed consent of the patient (or the patient's authorized representative) for the ordered genetic test(s) in accordance with applicable law. (Required)

Physician Signature

*Comprehensive analysis includes gene sequencing and deletion/duplication analysis

Name: _____ Name: _____

Name: _____ Name: _____

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VistaSeq® Hereditary Cancer Panel - Gene List

Gene Panel	Genes
Hereditary Cancer Panel	APC, ATM, BARD1, BMPR1A, BRCA1, BRCA2, BRIP1, CDH1, CDK4, CDKN2A, CHEK2, EPCAM, FAM175A, MLH1, MSH2, MSH6, MUTYH, NBN, PALB2, PMS2, PRKAR1A, PTEN, RAD51C, RAD51D, SMAD4, STK11, TP53
Hereditary Cancer Panel Minus BRCA1/2 genes	APC, ATM, BARD1, BMPR1A, BRIP1, CDH1, CDK4, CDKN2A, CHEK2, EPCAM, FAM175A, MLH1, MSH2, MSH6, MUTYH, NBN, PALB2, PMS2, PRKAR1A, PTEN, RAD51C, RAD51D, SMAD4, STK11, TP53
Breast Cancer Panel	ATM, BARD1, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, FAM175A, MRE11A, MUTYH, NBN, NF1, PALB2, PTEN, RAD50, RAD51C, RAD51D, STK11, TP53
High/Moderate Risk Breast Cancer Panel	ATM, BRCA1, BRCA2, CDH1, CHEK2, PALB2, PTEN, STK11, TP53
GYN Cancer Panel	BRCA1, BRCA2, CHEK2, EPCAM, MLH1, MSH2, MSH6, MUTYH, PMS2, PTEN, TP53
Breast and GYN Cancer Panel	ATM, BARD1, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, EPCAM, FAM175A, MRE11A, FANCC, MLH1, MSH2, MSH6, MUTYH, NBN, NF1, PALB2, PMS2, PTEN, RAD50, RAD51C, RAD51D, STK11, TP53
High Risk Colorectal Cancer Panel	APC, EPCAM, MLH1, MSH2, MSH6, MUTYH, PMS2
Colorectal Cancer Panel	APC, ATM, AXIN2, BLM, BMPR1A, BRCA1, BRCA2, CDH1, CDK2A, CHEK2, EPCAM, MLH1, MSH2, MSH6, MUTYH, PMS2, POLD1, POLE, PTEN, SMAD4, STK11, TP53
Brain/CNS/PNS Cancer Panel	ALK, APC, MEN1, MLH1, MSH2, MSH6, NBN, NF1, NF2, PHOX2B, PMS2, PTCH1, RB1, SMARCB1, SUFU, TP53, VHL
Endocrine Cancer Panel	CDC73, MAX, MEN1, NF1, PRKAR1A, PTEN, RET, SDHB, SDHC, SDHD, TMEM127, TP53, VHL
Pancreatic Cancer Panel	APC, ATM, BRCA1, BRCA2, CDKN2A, EPCAM, MLH1, MSH2, MSH6, PALB2, PMS2, STK11, TP53, VHL
Renal Cell Cancer Panel	EPCAM, FH, FLCN, GPC3, MET, MITF, MLH1, MSH2, MSH6, PMS2, PTEN, SDHB, SDHC, SDHD, TP53, TSC1, TSC2, VHL, WT1

BRCAssure® Test Components

Comprehensive Analysis	BRCA1 Target Analysis	BRCA2 Target Analysis	Ashkenazi Jewish Panel	BRCA1/2 Deletion/Duplication Analysis
Includes full gene sequencing and deletion/duplication analysis of BRCA1/2 genes	Includes sequencing of known familial mutation(s) on BRCA1 gene	Includes sequencing of known familial mutation(s) on BRCA2 gene	Includes screening for three known pathogenic variants: two in BRCA1 gene, and one in BRCA2 gene	Deletion/duplication analysis of BRCA1/2 genes

Lynch Syndrome Germline Testing - Individual Test List (Test Names / Test Code)

Individual Tests	Familial Tests with Known Mutations [▲]
MLH1 Comprehensive Analysis* (511615)	MLH1 (511635)
MSH2 Comprehensive Analysis* (511632)	MSH2 (511750)
MSH6 Comprehensive Analysis* (511636)	MSH6 (511765)
PMS2 Comprehensive Analysis* (511630)	PMS2 (511776)
EPCAM Deletion/Duplication Analysis (511654)	EPCAM Deletion/Duplication Analysis (511654)
MLH1 Deletion/Duplication Analysis (511690)	
MSH2 Deletion/Duplication Analysis (511705)	
MSH6 Deletion/Duplication Analysis (511720)	
PMS2 Deletion/Duplication Analysis (511725)	

*Comprehensive analysis includes gene sequencing and deletion/duplication analysis

[▲] Please attach a copy of family member's test results

Determining Necessity of Advance Beneficiary Notice of Noncoverage (ABN) Completion*

- Diagnose.** Determine your patient's diagnosis.
- Document.** Write the diagnosis code(s) on the front of this requisition.
- Verify.** Determine if the laboratory test(s) ordered for the patient is subject to the Local Coverage Determination or National Coverage Determination. This information can be located in the policies published by your Medicare Administrative Contractor (MAC), CMS, or www.LabCorp.com/MedicareMedicalNecessity.
- Review.** If the diagnosis code for your patient **does not** meet the medical necessity requirements set forth by Medicare or the test is being performed more frequently than Medicare allows, an ABN should be completed.

*An ABN should be completed for all tests that are considered investigational (experimental or for research use) by Medicare.

How to Complete an Advance Beneficiary Notice of Noncoverage (ABN)

Medicare is very specific in requiring that all of the information included on the ABN must be completed. Additionally, LabCorp requests that the specimen number or bar code label be included on the form. To be valid, an ABN must:

- Be executed on the CMS approved ABN form (CMS-R-131).
- Identify the Medicare Part B Beneficiary, using the name as it appears on the patient's red, white, and blue Medicare card.
- Indicate the test(s)/procedure(s) which may be denied within the relevant reason column.
- Include an estimated cost for the test(s)/procedures(s) subject to the ABN.
- Have "Option 1", "Option 2", or "Option 3" designated by the beneficiary.
- Be signed **and** dated by the beneficiary or his/her representative **prior to** the service being rendered.