Integrated ONCOLOGY
LabCorp Specialty Testing Group

Client Services
Brentwood, TN: (800) 874-8532 fax: (615) 370-8074
Phoenix, AZ: (800) 710-1800 fax: (800) 481-4151
New York, NY: (800) 447-5816 fax: (212) 698-9532

PROGNOSTIC/THERAPEUTIC PATHOLOGY

www.integratedoncology.com

Highlighted fields are REQUIRED

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:

Med. Rec. # / Patient #:

BILLING INFORMATION (attach face sheet and copy of insurance card – both sides)

Bill: ☐ My Account ☐ Insurance ☐ Medicare ☐ Medicaid ☐ Patient ☐ Workers Comp
Patient Hospital Status: ☐ In-Patient ☐ Out-Patient ☐ Non-Patient
Insurance Information: ☐ See attached Authorization # _____

PRIMARY BILLING PARTY	SECONDARY BILLING PARTY
INSURANCE CARRIER*	INSURANCE CARRIER*
ID #	ID #
GROUP #	GROUP #
INSURANCE ADDRESS	INSURANCE ADDRESS
NAME OF INSURED PERSON	NAME OF INSURED PERSON
RELATIONSHIP TO PATIENT	RELATIONSHIP TO PATIENT
EMPLOYER NAME	EMPLOYER NAME

*IF MEDICAID STATE | PHYSICIAN'S PROVIDER # | WORKERS COMP ☐ Yes ☐ No

CLINICAL/SPECIMEN INFORMATION

Collection Date: Time: Fixative: ☐ 10% Neutral Buffered Formalin

Send Date: ☐ Other:

Required for Breast Cancer: Time to Fixation: Hours Fixed:

Body Site/Descriptor: ☐ See previous case history

Specimen ID# (as it appears on the specimen):

Narrative Diagnosis/Clinical Data (please attach CBC, previous test results, if applicable):

☐ Paraffin Block(s): #_____ ☐ Slides: #_____ ☐ Smears: # _____
☐ Plasma: ☐ Other:_____

BLOCK PROCUREMENT

Block Location: Do you have possession of the block? ☐ Yes ☐ No
If No, indicate the location (below) and fax completed requisition to your lab location (see fax #s at top of requisition).

Facility Name:

Attention/Dept:

Address:

Phone Number: Fax Number:

CLINICAL INDICATION FOR STUDY (attach clinical history and pathology reports)

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	

When ordering tests for which Medicare or Medicaid reimbursements will be sought, physicians should order only those tests that are medically necessary for the diagnosis or treatment of the patient.

ⓘLynch Syndrome Comprehensive Tumor Evaluation includes MLH1/MSH2/MSH6/PMS2 (IHC), and MSI (PCR). If MLH1 is deficient, reflex to BRAF mutation analysis. If negative, reflex to MLH1^ promoter methylation. If ordering for endometrial cancer, BRAF mutation analysis will not be performed.

TESTING REQUESTED

IMMUNOHISTOCHEMISTRY LEVEL OF SERVICE – MUST SELECT ONE

☐ IHC stain with Manual Interpretation
☐ IHC stain with Quantitative Image Analysis (Global; Breast only)
☐ IHC stain - Technical Component only (slides)
☐ IHC stain with Virtual Image - Technical Component only

BREAST CANCER

HER2 requires formalin-fixed tissue; equivocal IHC results (2+) will be reflexed to FISH

Panels:
☐ ER♦, PR♦
☐ ER♦, PR♦, HER2 (IHC)♦
☐ ER♦, PR♦, HER2 (IHC)♦ ,Ki-67♦
☐ ER♦, PR♦, HER2 (FISH)
☐ ER♦, PR♦, HER2 (FISH), Ki-67♦

Reflex Options:
☐ HER2 (IHC); reflex ☐ 1+ ☐ 3+ to FISH
☐ HER2 (IHC); if IHC and FISH equivocal, reflex to HERmark®
☐ HER2 (FISH); if equivocal, reflex to IHC
☐ HER2 (FISH); if equivocal, reflex to HERmark®
☐ HER2 (IHC) and HER2 (FISH); if results equivocal, reflex to HERmark®

Individual Tests:
☐ ER♦ ☐ p53♦^ ☐ HERmark® ☐ HER2 (DUAL ISH TC ONLY)
☐ PR♦ ☐ DNA ploidy ☐ Tamoxifen CYP2D6 Genotype (PCR)
☐ HER2 (IHC)♦ ☐ E-Cadherin ☐ PIK3CA mutation analysis^
☐ Ki-67♦ ☐ HER2 (FISH) ☐ HER2 (DUAL ISH)

☐ **Prosigna® Breast Cancer Prognostic Gene Signature Assay**
☐ **ER, PR, HER2 (IHC); if ER/PR+ HER2-, reflex to Prosigna®**
REQUIRED FOR PROSIGNA®: Gross Tumor Size (must select one) ☐ ≤ 2 cm ☐ > 2 cm
Nodal Status (must select one) ☐ Negative ☐ 1-3 nodes

MSI by PCR: To note, tumor **and** normal tissue/peripheral blood required for MSI (PCR)
☐ If insufficient normal tissue submitted, perform MMR by IHC
☐ If insufficient normal tissue submitted, perform MSI by NGS

COLORECTAL CANCER

Panels:
☐ Comprehensive CRC Predictive Panel (Extended KRAS/NRAS, BRAF, MSI)
☐ Extended RAS/RAF Pathway Mutuation Panel (KRAS, NRAS, BRAF)
☐ Extended RAS Pathway Mutation Panel (KRAS, NRAS)

Individual Tests:
☐ KRAS extended mutation analysis (exons 2, 3, 4)★
☐ KRAS mutation analysis (codons 12, 13 RGQ PCR)
☐ NRAS extended mutation analysis (exons 2, 3, 4)★
☐ BRAF mutation analysis
☐ EGFR (FISH) ☐ MLH1 (IHC) ☐ MSH6 (IHC) ☐ MSI (PCR)
☐ UGT1A1 ☐ MSH2 (IHC) ☐ PMS2 (IHC)

Panels for Lynch Syndrome:
☐ Lynch Syndrome Comprehensive Tumor Evaluationⓘ
☐ MLH1/MSH2/MSH6/PMS2 (MMR IHC)
☐ Reflex to MSI (PCR) if any IHC marker listed above is not expressed
☐ Reflex to BRAF if MLH1 is not expressed (Colorectal cancer only)
☐ MSI (PCR); if unstable, reflex to MLH1/MSH2/MSH6/PMS2 (MMR IHC)

NON-SMALL CELL LUNG CANCER

Panels:
☐ Comprehensive NSCLC Predictive Panel (EGFR mutation, KRAS mutation, BRAF mutation, ALK [FISH], ROS1 [FISH], PD-L1 for KEYTRUDA® [IHC]¥)
☐ Oncomine® Dx Target Test (see reverse for gene list)

Reflex Options:
☐ EGFR mutation; if result wild-type, reflex to: ☐ KRAS ☐ ALK (FISH) ☐ ROS1 ☐ RET
☐ EGFR mutation and ALK; if results wild-type/negative, reflex to: ☐ ROS1 ☐ RET ☐ KRAS
☐ ALK; if result negative, reflex to ROS1 and RET

Individual Tests:
☐ EGFR mutation analysis ☐ ROS1 (FISH) ☐ ALK (D5F3) (IHC)
☐ KRAS mutation analysis ☐ RET (FISH) ☐ EGFR Mutation Test (cobas® v2)
☐ BRAF mutation analysis ☐ cMET (FISH)
☐ ALK (FISH) ☐ EGFR (FISH)

IMMUNOTHERAPY

Tests for Unstable DNA: ☐ MMR IHC (MLH1/MSH2/MSH6/PMS2) ☐ MSI (PCR)

PD-L1 (IHC)¥ (Tumor types listed per FDA-approved kit package insert)

PD-L1 KEYTRUDA®	PD-L1 OPDIVO®	PD-L1 TECENTRIQ®
☐ NSCLC	☐ Adenocarcinoma NSCLC	☐ NSCLC
☐ GASTRIC/GE Junc	☐ Melanoma	☐ Urothelial carcinoma
☐ Urothelial carcinoma	☐ SCC of the head and neck	
☐ Cervical	☐ Urothelial carcinoma	

GASTRIC CANCER

Equivocal HER2 IHC results (2+) will be reflexed to FISH

☐ HER2 (FISH) & HER2 (IHC) ☐ HER2 (IHC) ☐ HER2 (FISH)

TESTS FOR OTHER CANCERS

Melanoma: ☐ BRAF mutation analysis (V600E/K)
GIST: ☐ cKIT mutation analysis ☐ PDGFRA mutation analysis
Glioblastoma: ☐ 1p19q deletions (FISH) ☐ MGMT methylation ☐ IDH1/IDH2 mutation analysis
Thyroid: ☐ BRAF mutation analysis

IntelliGEN® ASSAY Original pathology report REQUIRED
☐ **IntelliGEN®** Oncology Therapeutic Panel (NGS) (489600)(see reverse for gene list)

Individual Tests: Offered to complement the IntelliGEN® panel, which must be ordered above.
☐ ALK (FISH) ☐ HER2 (IHC) ☐ cMET (FISH) ☐ RET (FISH)
☐ EGFR (FISH) ☐ HER2 (FISH) ☐ ROS1 (FISH)

Additional tests: (Please visit www.integratedoncology.com to see a complete list of our testing services)

*Peripheral blood only ^Investigational use only ♦Antibodies can be available by quantitative image analysis ¥ Global Only

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

1. **Diagnose.** Determine your patient's diagnosis.
2. **Document.** Write the diagnosis code(s) on the front of this requisition.
3. **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.
4. **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:

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

★Codons included in Colorectal Cancer Mutation Testing:

KRAS/NRAS

Exon 2 Codons 12 and 13
Exon 3 Codons 59 and 61
Exon 4 Codons 117 and 146

Oncomine® Dx Target Test - Gene List

EGFR	AKT1	DDR2	FGFR2	KIT	MAP2K2	NRAS	RAF1
RO1	ALK*	ERBB2	FGFR3	KRAS	MET*	PGFRA	RET*
BRAF	CDK4	ERBB3	HRAS	MA2K1	MTOR	PIKCA	

*The test reports fusion/translocation variants for ROS1 only. The test reports ALK, MET, RET mutations and does not report ALK, MET, and RET fusions/translocations.

IntelliGEN® Gene List

ABLI	BRAF	EGFR	FGFR1	GNAQ	IDH2	KRAS	NPM1	PTPN11	SMO
AKTI	CDH1	ERBB2	FGFR2	GNAS	JAK2	MET	NRAS	RB1	SRC
ALK	CDKN2A	ERBB4	FGFR3	HNF1A	JAK3	MLH1	PDGFRA	RET	STKII
APC	CSF1R	EZH2	FLT3	HRAS	KDR	MPL	PIK3CA	SMAD4	TP53
ATM	CTNNB1	FBXW7	GNAII	IDH1	KIT	NOTCH1	PTEN	SMARCB1	VHL

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