Germline Genetic Testing Requisition Form

Ambry Genetics® A Konica Minolta Company | CARIS® LIFE SCIENCES

Project Code: 120370

Caris Life Sciences will manage all logistics but germline testing will be performed by Ambry Genetics.
Customer Support may contact your office to obtain certain medical records that may be required by patient's insurance provider.

1. SPECIMEN INFORMATION

Collection Date

PLEASE COMPLETE THIS FORM AND INCLUDE IN THE RETURN KIT:

1. Clinic Notes 2. Pedigree 3. Insurance Card

2. PATIENT INFORMATION

Name (Last, First, MI)	Sex at Birth ☐F ☐M	Date of Birth (MM/DD/YY)	MRN

Ethnicity: ☐African American ☐Asian ☐White ☐Hispanic ☐Portuguese ☐Native American ☐Other: | Ashkenazi Jewish ☐Yes

Address	City	State	Zip

Phone	Email	Preferred Billing
		☐Insurance ☐Cash ☐Institutional

3. ORDERING PROVIDER INFORMATION

Organization Name, Number	Address	City, State	Zip

Ordering Provider Name (Last, First), Ambry Number		
☐	☐	☐

Other Provider Name (Last, First), Ambry Number		
☐	☐	☐

4. PATIENT CLINICAL HISTORY Attach clinic notes and/or pedigree

Personal History of Cancer ☐Yes ☐No	Age of Dx	Diagnosis Notes (cancer type, etc.) Metastatic: ☐Yes ☐No	ICD-10 Code(s)

Family History of Cancer ☐Yes ☐No	Family History Details (include relative, cancer type, and age of diagnosis)

Prior Genetic Testing, IHC, or MSI ☐Yes ☐No	Patient Testing Details	Family Members Testing Details

5. TEST ORDER

Primary Test Order

For Patients Meeting *BRCA1/2* Testing Criteria

☐ *BRCA1/2* test

For Patients Meeting Colorectal Cancer Syndrome Testing Criteria (Lynch)

Lynch Syndrome test: ☐ *MLH1, MSH2, MSH6, PMS2, EPCAM*

For Patients Meeting Colorectal Cancer Syndrome Testing Criteria (polyposis)

Polyposis test: ☐ *APC/MUYTH*

☐ Other: _____

☐ 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.)

☐ CancerNext-*Expanded*® 8874: NGS analysis of 77 genes from whole blood for hereditary cancer detection (DNA only)

☐ CancerNext-*Expanded* +RNAinsight® 8874-R: (DNA and RNA) - additional PAXgene® RNA tube required

Genes:

*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, MITF, 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*

***Genes eligible for RNA analysis*

Will the course of treatment change depending upon the results of the test? ☐Yes ☐No

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 the patient responsibility amount for germline genetic testing.

☐ I consent to transfer ownership of my remaining sample to Ambry Genetics and Caris Life Sciences. **Note:** If I am a NY state resident or if left blank, my sample will be destroyed 60-days after the results are reported.

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.

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.

Blood/saliva 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 recommended. Testing on blood/saliva from patient with active hematological disease is not recommended. An alternative specimen (e.g. cultured fibroblasts) is recommended.

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