HEREDITARY CANCER TEST REQUISITION

progenity® AVERO™

PATIENT INFO

NAME | PATIENT ID NUMBER

DATE OF BIRTH (MM/DD/YYYY) | SEX ☐ Female ☐ Male

ETHNICITY

☐ Asian ☐ French Canadian/Cajun ☐ Jewish, non-Ashkenazi ☐ Native American
☐ African American ☐ Hispanic ☐ Middle Eastern
☐ Caucasian ☐ Jewish, Ashkenazi ☐ Other/Mixed/Unknown _____

TELEPHONE NUMBER | E-MAIL

ADDRESS / CITY / STATE / ZIP

ACKNOWLEDGEMENT: I authorize the laboratory to provide to my health plan the information on this form and other information provided by my healthcare provider if necessary for reimbursement. I understand that the laboratory may seek prior authorization for testing from my health plan on my behalf. I also authorize all benefits of the plan to be payable directly to the laboratory, and I agree to remit to the laboratory any payment for these services made directly to me. I understand that the laboratory may be an out-of-network provider for my health plan and that I am responsible for all amounts not reimbursed by my health plan. I hereby designate the laboratory as my Authorized Representative, as provided under ERISA, 29 C.F.R. § 2560.5031(b)(4), and/or as my Attorney in Fact, for the purpose of pursuing administrative appeals to which I am entitled and, if the laboratory deems it appropriate, any legal and/or equitable claims that I could bring against my health plan, and/or its fiduciaries, and/or its administrators, with respect to their handling or resolution of my insurance claim.

☐ I authorize the laboratory to retain and use my de-identified specimen and test data (where all information that could link me to the specimen or data has been removed) for research and/or to help develop new products or services, in compliance with applicable laws.

☐ I do not authorize the laboratory to retain and use my de-identified specimen and test data as described above.

If signature is present but box is not checked, consent is implied. All leftover specimens from New York State will be destroyed within 60 days.

REQUIRED — PATIENT SIGNATURE | DATE (MM/DD/YY)

X

PATIENT NAME

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CLINICIAN INFO

PROGENITY ACCOUNT NUMBER

ORDERING CLINICIAN NAME / NPI#

CLINIC NAME

TELEPHONE NUMBER | FAX NUMBER

ADDRESS / CITY / STATE / ZIP

ACKNOWLEDGEMENT: I hereby confirm that information has been provided to the patient about the test(s) to be performed and the patient has given consent as required under applicable laws and regulations for the test(s) to be performed. The test(s) to be performed are medically necessary and the results will be used for medical management and treatment decision purposes for this patient. I confirm that the person listed as the Ordering Clinician is authorized by law to order the test(s) requested herein.

REQUIRED — ORDERING CLINICIAN SIGNATURE | DATE (MM/DD/YY)

X

GENETIC COUNSELOR NAME / NPI#

TELEPHONE NUMBER | E-MAIL | FAX NUMBER

ADDITIONAL REPORTS TO: CLINICIAN NAME / NPI# | FAX NUMBER

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BILLING INFO

☐ **BILL INSURANCE** (Attach legible front and back copy of insurance cards)

NAME OF INSURED | INSURANCE COMPANY

MEMBER ID | GROUP # | PRE-AUTHORIZATION #, IF OBTAINED

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☐ **BILL PATIENT** Please call us to review payment options.

☐ **BILL ORDERING CLINICIAN**

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Collection Requirement: 1 x (4) lavender-top EDTA tube **OR** 1 x (O) ORAcollect® buccal swab **OR** 1 x (M) 15 mL mouthwash

SPECIMEN INFO: Date Collected (MM/DD/YY) _____ Time Collected ☐ AM ☐ PM Collected by: _____

TESTS REQUESTED (SEE DESCRIPTIONS ON REVERSE)

☐ **Riscover™ Comprehensive**
Analysis of 31 genes related to breast, ovarian, endometrial, colorectal, and other cancers.

☐ **Riscover™ BRCA**
Analysis of 2 genes related to hereditary breast, ovarian, and other cancers.
☐ Limit to **Riscover™ BRCA Ashkenazi Jewish Three-Site Analysis**

☐ **Riscover™ Lynch Syndrome**
Analysis of 5 genes related to hereditary colorectal, endometrial, and other cancers.

☐ **Known Family Variant** Gene _____ Variant _____
A copy of the affected relative's result report is required.
If the relative was tested at Progenity, please provide:
Full name: _____
Date of birth: _____
Relationship to patient: _____
☐ Check if this testing is for the Variant Classification Program (only the familial variant of uncertain significance will be tested)

☐ **Other:** _____

REQUISITION CHECKLIST

DID YOU INCLUDE?

☐ Riscover™ Cancer Compass family history form (both sides) REQUIRED
☐ ICD-10 diagnosis code(s) REQUIRED
☐ Patient's insurance card (legible front and back copy) REQUIRED
☐ Patient clinical history (if personal history of cancer)
☐ Genetic counseling visit notes (if performed)
☐ Results for any previous testing
  ☐ Previous genetic testing on patient
  ☐ Previous genetic testing on patient's family members
  ☐ Tumor testing results, such as MSI/IHC for colorectal or uterine cancer

PATIENT CLINICAL HISTORY

REQUIRED — **Has patient ever been diagnosed with cancer?**
☐ **Yes** – *complete the section below and attach relevant records.* ☐ **No**

☐ **BREAST CANCER** ☐ left ☐ right ☐ bilateral
Age at dx: _____
☐ pre-menopausal ☐ post-menopausal
Pathology: ☐ ductal invasive [Z85.3] ☐ DCIS [Z86.000]
☐ lobular invasive [Z85.3] ☐ other: _____
Triple negative? (ER-, PR-, Her2/neu -) ☐ Yes ☐ No

☐ **OVARIAN CANCER** [Z85.43] (female patients)
Age at dx: _____
Pathology: _____

☐ **UTERINE / ENDOMETRIAL CANCER** [Z85.42] (female patients)
Age at dx: _____
Pathology: _____
Was tumor screening performed? ☐ Yes ☐ No
If "Yes," attach results.

☐ **PROSTATE CANCER** [Z85.46] (male patients)
Age at dx: _____ Gleason score: _____

☐ **COLORECTAL CANCER**
Location: ☐ colon [Z85.030] ☐ rectum [Z85.040]
Age at dx: _____
Pathology: _____
Was tumor screening performed? ☐ Yes ☐ No
If "Yes," attach results.

☐ **GI POLYPS** [Z86.010]
Age at dx: _____ Number of polyps: _____
Pathology: ☐ adenomatous ☐ other type: _____

☐ **HEMATOLOGIC CANCER**
Age at dx: _____
Pathology: _____
Was bone marrow or stem cell transplant performed? ☐ Yes ☐ No

☐ **OTHER CANCER** Age at dx: _____
Type: _____

Is patient adopted with no family history? ☐ Yes ☐ No

Additional information:

ADDITIONAL CLINICAL INFO

PREVIOUS CANCER GENETIC TESTING
☐ No previous testing
☐ Testing performed: *(Attach results if available)*
gene(s) tested: _____
results: _____

GENETIC COUNSELING PERFORMED? ☐ Yes ☐ No
Date of GC visit: _____/_____/_____
Please attach GC visit note.

OTHER RELEVANT CLINICAL HISTORY

REQUIRED: ICD-10 Code(s)
Commonly used codes are noted above and additional codes are listed on the reverse.

WH-27015-01 REV 082017

PATIENT NAME	PATIENT NAME	PATIENT NAME	PATIENT NAME
DOB	DOB	DOB	DOB

MARGINAL TEXT

RISCOVER™ PANEL DESCRIPTIONS

Riscover™ Comprehensive
Analysis of *APC, ATM, BARD1, BMPR1A, BRCA1, BRCA2, BRIP1, CDH1, CDK4, CDKN2A, CHEK2, EPCAM, MEN1, MLH1, MSH2, MSH6, MUTYH, NBN, NF1, PALB2, PMS2, POLD1, POLE, PTEN, RAD51C, RAD51D, RET, SMAD4, STK11, TP53, VHL*

Riscover™ BRCA
Sequence and deletion/duplication analysis for *BRCA1* and *BRCA2*

Riscover™ BRCA Ashkenazi Jewish Three-Site Analysis
Targeted analysis of three mutations: *BRCA1* c.68_69delAG; *BRCA1* c.5266dupC; *BRCA2* c.5946delT

Riscover™ Lynch Syndrome
Sequence and deletion/duplication analysis for *MLH1, MSH2, MSH6,* and *PMS2;* Deletion/duplication analysis only for *EPCAM*

ICD-10 CODES

PERSONAL HISTORY OF CANCER

Personal history of malignant carcinoid tumor of large intestine	Z85.030
Personal history of other malignant neoplasm of large intestine	Z85.038
Personal history of malignant carcinoid tumor of rectum	Z85.040
Personal history of other malignant neoplasm of rectum, rectosigmoid junction, and anus	Z85.048
Personal history of malignant neoplasm of pancreas	Z85.07
Personal history of malignant neoplasm of breast	Z85.3
Personal history of malignant neoplasm of other parts of uterus	Z85.42
Personal history of malignant neoplasm of ovary	Z85.43
Personal history of malignant neoplasm of prostate	Z85.46
Personal history of in-situ neoplasm of breast	Z86.000
Personal history of colonic polyps	Z86.010

FAMILY HISTORY OF CANCER

Family history of malignant neoplasm of breast	Z80.3
Family history of malignant neoplasm of ovary	Z80.41
Family history of malignant neoplasm of prostate	Z80.42
Family history of malignant neoplasm of other organs or systems	Z80.8
Family history of malignant neoplasm, unspecified	Z80.9
Family history of colonic polyps	Z83.71
Family history of carrier of genetic disease	Z84.81

LIMITED OR NO FAMILY HISTORY

Genetic susceptibility to malignant neoplasm of breast	Z15.01
Genetic susceptibility to malignant neoplasm of endometrium	Z15.04
Genetic susceptibility to malignant neoplasm of ovary	Z15.02
Genetic susceptibility to malignant neoplasm of prostate	Z15.03
Genetic susceptibility to other malignant neoplasm	Z15.09

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