Cancer Test Requisition Form (Abbreviated)

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

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

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

2. 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	Preferred Billing ☐Insurance ☐Self-pay ☐Institutional

3. ORDERING PROVIDER INFORMATION

Organization Name, Number	Address	City, State	Zip

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

Genetic Counselor/Other Healthcare Professional Name (Last, First), Ambry Number		
☐	☐	☐

4. PERSONAL AND FAMILY HISTORY OF CANCER

Attach clinic notes and/or pedigree

Personal History of Cancer: ☐Yes ☐No	Age of Dx:	Metastatic: ☐Yes ☐No	Tumor is ☐MSI-High or ☐IHC-Abnormal	ICD-10 Code(s)
Testing could aid in systemic therapy and/or surgical decision-making for my affected patient ☐Yes ☐No			Abnormal IHC Result:	

Patient Cancer Type Details: ☐TNBC

Family History of Cancer: ☐Yes ☐No | Known Familial Variant: ☐Family ☐Self Gene: _____ Variant (c. and/or p.): _____

Relationship to Patient	Mat	Pat	Age at Dx	Family Testing and Cancer Type Details	Reason relative has not been tested
	☐	☐			☐Deceased ☐Declines ☐No Contact
	☐	☐			☐Deceased ☐Declines ☐No Contact
	☐	☐			☐Deceased ☐Declines ☐No Contact
	☐	☐			☐Deceased ☐Declines ☐No Contact
	☐	☐			☐Deceased ☐Declines ☐No Contact

5. TEST ORDERS

! REQUIRED: Select a 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/MUTYH*

☐ 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® (8824)
☐ BRCAplus® (8836)
☐ BRCANext® (8857)
Add on: ☐ Limited Evidence
☐ ColoNext® (8821)
Add on: ☐ Limited Evidence

☐ CancerNext-*Expanded*® (8875)
Add on: ☐ Limited Evidence ☐ Pancreatitis
☐ CustomNext-*Cancer*® (9511)
Notes: _____
☐ Specific Site Analysis (5555): Proband report is required.
Gene_____ Variant (c./p.):_____
☐ Other: _____

Other Supplemental Test Options (Select if applicable)

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

Collection Assistance: ☐ Phlebotomy draw ☐ Send saliva kit to patient

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 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: ☐ By checking this box, I agree that Ambry Genetics will retain my sample for 6 months after the testing above has been completed. By not checking this box, I understand that under New York State law, Ambry Genetics must discard my sample after the longer of (a) testing completion and (b) 60 days after the Date of Collection above.

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.

Ambry Genetics®

Patient Name: _____ DOB: _____

Supplemental Information

Hereditary Cancer Multi-Gene Tests

TEST NAME	TEST CODE	GENES
Pan-cancer		
CancerNext® (39 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, SMAD4, STK11, TP53, TSC1, TSC2, VHL*
CancerNext-*Expanded*® (76 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, 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 (9 genes): *ATRIP, EGLN1, KIF1B, MLH3, PALLD, RAD51B, RNF43, RPS20, 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® (20 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, SMAD4, STK11, TP53* Optional Add-on - Limited Evidence Genes (6 genes): *ATM, CHEK2, CTNNA1, MLH3, RNF43, RPS20*
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*

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.

7 Argonaut, Aliso Viejo, CA 92656 USA Toll Free +1.866.262.7943 Fax +1.949.900.5501 **ambrygen.com**

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