Ambry Genetics®
A TEMPUS COMPANY

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.): _____ Ambry ID: _____
See instructions on the Supplemental Information Page

☐My patient is the most informative family member available for testing. The affected relative and all intervening relatives are either deceased or unwilling/unavailable for testing.

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)

☐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: _____
☐Known Variant 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 ☐Send buccal swab 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 on the next page): Date:

Medical Professional Signature (I agree to terms on the next page): Date:

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Patient Name: _____ DOB: _____

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.

For patient payment by credit card: I hereby authorize Ambry Genetics Corporation to bill my credit card as indicated above.

For NY Residents: ☐ I understand that New York State law requires Ambry Genetics to destroy my sample at the end of the testing process or not more than sixty days after the sample was taken. By checking this box, I agree that Ambry Genetics will instead retain my sample for at least 6 months after the testing above has been completed, and may (a) retain and use samples and health information for an indefinite period of time in accordance with applicable law; and (b) de-identify such samples and information and use and share the resulting de-identified samples and information in accordance with applicable law.

Medical Professional: Confirmation of Informed Consent, Pre-test Genetic Counseling, and Medical Necessity for Genetic Testing
By signing and/or submitting the order: I certify that (1) the patient has received an explanation of the purpose, risks, and benefits of the ordered test(s); (2) the ordered test(s) are medically necessary and will inform the patient's treatment plan; and (3) the patient has provided informed consent that meets the requirements of applicable law for Tempus/Ambry or its reference lab to: (a) collect and use the patient's samples (including genetic material) and health information and perform the ordered test(s); (b) obtain, receive, and release health information (including test results) as necessary for reimbursement or the processing of insurance claims; (c) retain and use samples and health information for an indefinite period of time in accordance with applicable law; and (d) de-identify such samples and information and use and share the resulting de-identified samples and information in accordance with applicable law. I agree to allow Tempus/Ambry to facilitate the provision of pre-test genetic counseling services by a third-party service, as required by the patient's insurance provider.

Supplemental Information

Electronic ordering is also available via AmbryPort®. Please visit https://portal.ambrygen.com/login to log in to the online portal.

Hereditary Cancer Multi-Gene Tests

For current hereditary cancer panel gene content, please visit www.ambrygen.com/providers/oncology/test-menu (linked to QR code below).

TEST NAME	TEST CODE
Pan-cancer	
CancerNext®	8824
CancerNext-*Expanded*®	8875
STAT Breast Management	
BRCAPlus®	8836
Breast & gynecologic	
BRCANext®	8857
Colorectal & polyposis	
ColoNext®	8821
Customizable	
CustomNext-*Cancer*® Required: complete CustomNext-*Cancer* supplemental form. ambrygen.com/forms	9511
Syndrome specific	
Adenomatous polyposis	8726
BRCA1/2-associated hereditary breast and ovarian cancer (HBOC)	8838
Lynch syndrome	8517

Scan for current hereditary cancer panel gene content

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.

Buccal swab samples 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 required. Testing on buccal swab samples from patients with active hematological disease is not recommended. An alternative specimen (e.g. cultured fibroblasts) is recommended. Please see ambrygen.com/specimen-requirements for details.

Known variant analysis should be accompanied by a copy of the original testing report or internal Ambry testing information (internal Ambry ID, Name/DOB). Please review information about positive controls and other specifics at ambrygen.com/knownvariantanalysis.

Known Familial Variants

Variant-specific report comments about the presence or absence of known familial variant(s) require the "Known Familial Variant" section of this form to be completed accurately, including an internal Ambry reference ID and/or a copy of the positive family member's lab report. Acceptable types of Ambry identifiers include:

- Accession number
- Order number
- Name and date of birth

Variant requests without an internal Ambry reference ID or positive family member's lab report will not receive a variant-specific report comment.

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