

CLIENT INFORMATION	
ORDERING PHYSICIAN	NPI #
TREATING PHYSICIAN	NPI #
PHYSICIAN/AUTHORIZED SIGNATURE	
Client#	
Client Name	
Address	
Phone Number	Fax Number

PATIENT INFORMATION	
Name (LAST, FIRST, MIDDLE):	
Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Address:	
City, State, Zip:	
Phone Number:	
Med. Rec. # / Patient #:	

BILLING INFORMATION (attach face sheet and copy of insurance card – both sides)	
Bill: <input type="checkbox"/> My Account <input type="checkbox"/> Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Patient <input type="checkbox"/> Workers Comp	
Patient Hospital Status: <input type="checkbox"/> In-Patient <input type="checkbox"/> Out-Patient <input type="checkbox"/> Non-Patient	
Insurance Information: <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No

SPECIMEN INFORMATION	
Collection Date:	Time: <input type="checkbox"/> AM <input type="checkbox"/> PM
Send Date:	<input type="checkbox"/> Other:
Specimen ID# (as it appears on the specimen):	
Body Site/Descriptor:	
Fixative: <input type="checkbox"/> 10% Neutral Buffered Formalin <input type="checkbox"/> Other:	Hours Fixed:
Specimen Type (for complete specimen requirements see reverse)	
<input type="checkbox"/> FFPE Block	<input type="checkbox"/> Unstained slides #
<input type="checkbox"/> BM Aspirate	<input type="checkbox"/> BM Core
<input type="checkbox"/> BM Clot	<input type="checkbox"/> FNA-Source:

CLINICAL INDICATION FOR STUDY (attach clinical history and pathology reports)		
Narrative Diagnosis/Clinical Data (please attach previous test results, if applicable):		
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.

Integrated Oncology is a brand used by both Accupath Diagnostic Laboratories, Inc. and Esoterix Genetic Laboratories, LLC, wholly-owned subsidiaries of Laboratory Corporation of America® Holdings.

BLOCK PROCUREMENT	
Block Location: Do you have possession of the block? <input type="checkbox"/> Yes <input type="checkbox"/> 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:

OMNISEQ® ASSAYS (see reverse for assay details)
Note: A copy of the original pathology report is REQUIRED for OmniSeq testing. See reverse for detailed specimen requirements
Required information for the OmniSeq Assays: Primary Cancer Tumor Type: <input type="checkbox"/> Lung <input type="checkbox"/> Breast <input type="checkbox"/> Colon <input type="checkbox"/> Melanoma <input type="checkbox"/> Kidney
Other: _____
Stage: _____
<input type="checkbox"/> OmniSeq INSIGHT™ Assay (for targeted therapy and immune profiling)
OmniSeq Reflex Option – Lung Cancer Only
<input type="checkbox"/> OmniSeq INSIGHT, if tissue submitted is insufficient for testing, reflex to Resolution ctDx Lung Assay*
*Integrated Oncology Client Services will call ordering physician if tissue is found insufficient to request a peripheral blood sample

IntelliGEN® NGS ASSAY (see reverse for the gene list)
<input type="checkbox"/> IntelliGEN® Myeloid for AML, MDS, MPN (451953)
Indication: _____

PROSIGNA® ASSAY
<input type="checkbox"/> Prosigna® Breast Cancer Prognostic Gene Signature Assay (481210)
Important Note:
REQUIRED: Gross Tumor Size (must select one) <input type="checkbox"/> ≤2cm <input type="checkbox"/> > 2cm
REQUIRED: Nodal Status (must select one) <input type="checkbox"/> Negative <input type="checkbox"/> 1-3 nodes

RESOLUTION CTDx LUNG™ (see reverse for gene list) Blood Only; use liquid biopsy kit tubes
<input type="checkbox"/> Resolution Bioscience ctDx Lung™ Liquid Biopsy Assay (830697)
Stage: <input type="checkbox"/> III <input type="checkbox"/> IV
Current Therapy: _____
Previous Therapy: _____
<input type="checkbox"/> Adenocarcinoma (NSCLC)
<input type="checkbox"/> Large Cell Carcinoma (NSCLC)
<input type="checkbox"/> Squamous Cell Carcinoma (NSCLC)
<input type="checkbox"/> Lung Carcinoid/Neuroendocrine Small Cell Lung Carcinoma
<input type="checkbox"/> Non-small cell lung cancer (NSCLC)
Relevant Testing History (must choose one):
<input type="checkbox"/> At Diagnosis: Patient has NOT had Comprehensive Genomic Profiling (EGFR, ALK, ROS1, BRAF) and tissue testing is not feasible or unavailable
<input type="checkbox"/> At Progression: Patient has NOT had Comprehensive Genomic Profiling (EGFR, ALK, ROS1, BRAF) and tissue testing is not feasible or unavailable
<input type="checkbox"/> At Progression: Patient progressing on tyrosine kinase inhibitors (TKIs)

OTHER TESTS (Please visit www.integratedoncology.com to see a complete list of our testing services)
Please request additional tests by writing in the space below:

OmniSeq® Specimen Requirements

Tissue Submission Guidelines	All blocks and slides must at a minimum be labeled with the pathology case number and part. Reports and other provided materials must be labeled with the pathology case number and at least two patient identifiers, such as name, medical record number or date of birth. PLEASE INCLUDE THE PATHOLOGY REPORT.
Recommended Specimen Submission	**DO NOT SUBMIT Decalcified Specimens, Cytology Smears or samples from hematologic malignancies** The preferred specimen is at least one FFPE block. If a block cannot be provided, see slide requirements below. Specimens with very small amounts of tumor and/or less than requested number of slides will be accepted with the caveat that complete testing may not be possible. Specimens should be selected by a board-certified pathologist and should contain neoplastic and normal tissue, where indicated. It is recommended that USS are cut using standard DNA/RNA precautions (change microtome blade, wipe stage, never re-use blade for more than one case and remove floaters in water bath between cases).
Slide Requirements	OmniSeq INSIGHT: Block is preferred, or send 20 unbaked, positively charged, unstained slides cut at 5 µm.

IntelliGEN® Myeloid Panel Gene List

ABL1, ASXL1, BCOR, BCORL1, BRAF, CALR, CBL, CDKN2A, CEBPA, CSF3R, CUX1, DNMT3A, ETV6, EZH2, FBXW7, FLT3, GATA1, GATA2, IDH1, IDH2, IKZF1, JAK2, JAK3, KDM6A, KIT, KMT2A, KRAS, MPL, NF1, NOTCH1, NPM1, NRAS, PDGFRA, PHF6, PML, PTEN, PTPN11, RAD21, RUNX1, SETBP1, SF3B1, SMC1A, SMC3, SRSF2, STAG2, TET2, TP53, U2AF1, WT1, ZRSR2

IntelliGEN® Myeloid Panel Specimen Requirements

Specimen: Whole blood, bone marrow, cell pellets from whole blood, or cell pellets from bone marrow
Volume: 3-5 mL (Blood), 1-2 mL (Bone Marrow)
Container: Lavender-top (EDTA) tube or green-top (heparin) tube

Prosigna® Sample Requirements

The **gross size** of the patient's primary tumor and **nodal status** are required to perform the assay. A copy of the original pathology report is required for testing. If a pathology report is not received, testing will be delayed.

Solid Tumor (SEE NOTE)

Formalin-Fixed paraffin embedded tissue. Fixative should be neutral buffered formalin.

Block

Formalin-Fixed paraffin embedded tissue block

Unstained slides

Up to six unstained slides (see table below) at 10 µm and one matching H&E-stained slide. The tumor cellularity percentage within the circled tumor area on the H&E-stained slide must be ≥10%. The circled tumor surface area on the H&E-stained slide must be ≥4mm².

Measured tumor surface area on H&E-stained slide (mm ²)	Number of unstained slides needed (each slide cut at 10 µm sections)
4-19	6
20-99	3
≥ 100	1

Note:

1. The Prosigna® assay is not intended for patients with 4 or more positive nodes.
2. Micrometastases were not considered node positive during the Prosigna® assay validation, so it should be considered as a negative node.
3. Only invasive breast carcinoma is qualified for Prosigna® assay. DCIS (ductal carcinoma in situ) is not qualified for the Prosigna® assay.
4. The Prosigna® assay is intended for use only on formalin-fixed paraffin-embedded (FFPE) breast cancer tissue specimens from surgical resections. It is not intended for use on needle biopsy samples, fresh, frozen or non-breast cancer tissue.
5. Multifocal breast tumor should not be combined. Each should be considered as an independent tumor.

Resolution ctDx Lung™ Liquid Biopsy Assay Gene List

AKT1, ALK, B2M, BRAF, EGFR, ERBB2 (HER2), FGFR1, FGFR2, FGFR3, KEAP1, KRAS, MAP2K1 (MEK1), MET, MYC, NRAS, NTRK1, PIK3CA, PTEN, RET, RICTOR, ROS1, STK11, TP53

Determining Necessity of Advance Beneficiary Notice of Non-coverage (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 Non-coverage (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.

Patient, client, and billing information is requested for timely processing of this case. Medicare and other third party payors require that services be medically necessary for coverage, and generally do not cover routine screening tests.

Refer to Determining Necessity of ABN Completion.

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