labcorp | Oncology

Client Services
TN: (800) 874-8532 fax: (615) 370-8074
AZ: (800) 710-1800 fax: (800) 481-4151
CT: (800) 447-5816 fax: (212) 698-9532

HEREDITARY CANCER TESTING

oncology.labcorp.com

Highlighted fields are REQUIRED

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: Male Female

Address:

City, State, Zip:

Phone Number: MRN / PT ID#:

BILLING INFORMATION (face sheet & front and back of insurance card must be attached)

Bill: My Account | Insurance | Medicare | Medicaid | Patient | Workers Comp | See attached

Patient Hospital Status: InPatient OutPatient Non-Patient

Insured Information: Name

Relationship to Patient (circle one) Self Spouse Child Other:

Primary Insurance Co: Authorization #

Billing Address Insured #

Billing City, State, Zip Group #

SPECIMEN INFORMATION

Collection Date: _____ Time: _____ ■ AM ■ PM

Specimen Type: ■ Peripheral Blood Specimen ID #: _____

PATIENT CLINICAL CANCER HISTORY

☐ No personal history of cancer

☐ Breast: Invasive or DCIS, age at Dx _____

(Check all that apply) ☐ Bilateral ☐ Premenopausal ☐ Triple Negative (ER-, PR-, HER-)

☐ Ovarian: Age at Dx _____ ☐ Endometrial: Age at Dx _____

☐ Prostate: Age at Dx _____ If Prostate, Gleason score: _____

☐ Pancreatic: Age at Dx _____ ☐ Renal: Age at Dx _____

☐ Endocrine: Age at Dx _____ Type: ☐ Thyroid ☐ Pheochromocytoma ☐ Paraganglioma

☐ Colorectal: Age at Dx _____

MSI Testing Done: ☐ Yes ☐ No MSI Result: ☐ High ☐ Stable ☐ Low

IHC Testing Done: ☐ Yes ☐ No IHC Result: ☐ Present ☐ Absent IHC of _____

MLH1 Methylation status: ☐ Not done ☐ Methylated tumor only

☐ Methylated tumor and normal tissue ☐ Unmethylated

BRAF V600E: ☐ Not Done ☐ Present ☐ Absent

☐ Colon Polyps: Age of first polyp _____ If Adenomatous, total # _____

☐ Other Cancers: Type _____ Age(s) of Dx: _____

☐ History of Bone Marrow Transplant: ☐ Yes ☐ No If yes, please contact us at 800-345-4363 prior to sample collection.

☐ History of blood transfusion, date of last transfusion _____

CLINICAL INDICATION (attach previous test results if applicable)

Narrative Diagnosis: _____

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	

Genetic Counseling Provided: ☐ Yes ☐ No Counselor name: _____

Institution: _____ Phone #: _____

Note: Some insurance companies require genetic counseling before approving BRCAssure and VistaSeq testing. If you are unsure, please contact us at 855-488-8750.

TEST REQUEST

▲ Please attach a copy of family member's test results

VISTASEQ® HEREDITARY CANCER TESTS (See reverse side for gene list)

Panels:

☐ Hereditary Cancer Panel (27 Gene Assay) (481220)
☐ Hereditary Cancer Panel Minus BRCA1/2 genes (25 Gene Assay) (481240)
☐ Breast Cancer Panel (19 Gene Assay) (481319)
☐ High/Moderate Risk Breast Cancer Panel (9 Gene Assay) (481452)
☐ GYN Cancer Panel (11 Gene Assay) (481330)
☐ Breast and GYN Cancer Panel (25 Gene Assay) (481341)
☐ High Risk Colorectal Cancer Panel (7 Gene Assay) (481352)
☐ Colorectal Cancer Panel (22 Gene Assay) (481363)
☐ Brain/CNS/PNS Cancer Panel (17 Gene Assay) (481386)
☐ Endocrine Cancer Panel (13 Gene Assay) (481374)
☐ Pancreatic Cancer Panel (14 Gene Assay) (481385)
☐ Renal Cell Cancer Panel (19 Gene Assay) (481407)
☐ Lynch Syndrome Panel (5 Gene Assay) (483543)
☐ Prostate Cancer Panel (10 Gene Assay) (483555)

Single Genes:

☐ APC Comprehensive Analysis* (483484)
☐ MEN1 Comprehensive Analysis* (483460)
☐ RET Comprehensive Analysis* (483472)

HEREDITARY BREAST AND OVARIAN CANCER (test components on back)

☐ BRCAssure® Comprehensive Analysis* (485030)
☐ BRCAssure® BRCA1 Targeted Analysis▲ (485066)
☐ BRCAssure® BRCA2 Targeted Analysis▲ (485081)
☐ BRCAssure® Ashkenazi Jewish Panel (485097)

LYNCH SYNDROME GERMLINE TESTING

☐ VistaSeq® Lynch Syndrome Panel (483543)
☐ VistaSeq® MLH1 Comprehensive Analysis* (483496)
☐ VistaSeq® MSH2 Comprehensive Analysis* (483508)
☐ VistaSeq® MSH6 Comprehensive Analysis* (483520)
☐ VistaSeq® PMS2 Comprehensive Analysis* (483532)
☐ EPCAM Deletion/Duplication Analysis (511654)

Individual Tests: _____

See reverse side for additional individual gene test list and write in test name/test code in the space above

☐ **Mutation Specific Sequencing (451382)**
Required: Gene(s): _____
Mutation(s): _____

PREVIOUS GENETIC TESTING FOR CANCER

Has the patient had genetic testing for cancer? If yes, please document the gene(s) tested and results: _____

FAMILY HISTORY

▲ Please attach a copy of family member's test results

Is there a family history of cancer? ☐ Yes ☐ No ☐ Unknown

Other family members tested positive for a hereditary cancer syndrome? ☐ Yes ☐ No
Type▲: _____

Is the patient adopted? ☐ Yes ☐ No ☐ Unknown

Does the patient have Ashkenazi Jewish Ancestory? ☐ Yes ☐ No

Please attach pedigree or complete table below. Is a pedigree attached? ☐ Yes ☐ No

Relationship (Father, Sister, Aunt, etc.)	Maternal or Paternal Please indicate	Relative Available for Testing? If no, please state reason	Known Mutation? If yes, please attach lab report	Cancer Type	Age at Diagnosis

Patient understands by signing below:

Labcorp may use information obtained on this form and other information provided by me and/or my ordering provider or his/her designee to initiate preauthorization with my health plan as required. I understand a preauthorization approval from my health plan does not guarantee full payment.

Labcorp will attempt to contact me if my estimated out-of-pocket payment is more than $300. Testing may be canceled if Labcorp is unable to reach me. No matter my estimated cost, my actual out-of-pocket cost may be higher or lower than the estimate provided. It is my responsibility to contact my health plan regarding concerns over my coverage and benefits.

Patient's Signature (required) _____

Patient Phone Number: _____

☐ Prior-authorization form has been sent separately.

Please contact Prior Authorization at 855-488-8750 if you have any questions about our service.

INFORMED CONSENT

I have obtained informed consent of the patient (or the patient's authorized representative) for the ordered genetic test(s) in accordance with applicable law. (Required)

_____
Physician Signature

*Comprehensive analysis includes gene sequencing and deletion/duplication analysis

VistaSeq® Hereditary Cancer Panels - Gene List

Gene Panel	Genes
Hereditary Cancer Panel	*APC, ATM, BARD1, BMPR1A, BRCA1, BRCA2, BRIP1, CDH1, CDK4, CDKN2A, CHEK2, EPCAM, FAM175A, MLH1, MSH2, MSH6, MUTYH, NBN, PALB2, PMS2, PRKAR1A, PTEN, RAD51C, RAD51D, SMAD4, STK11, TP53*
Hereditary Cancer Panel Minus BRCA1/2 genes	*APC, ATM, BARD1, BMPR1A, BRIP1, CDH1, CDK4, CDKN2A, CHEK2, EPCAM, FAM175A, MLH1, MSH2, MSH6, MUTYH, NBN, PALB2, PMS2, PRKAR1A, PTEN, RAD51C, RAD51D, SMAD4, STK11, TP53*
Breast Cancer Panel	*ATM, BARD1, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, FAM175A, MRE11A, MUTYH, NBN, NF1, PALB2, PTEN, RAD50, RAD51C, RAD51D, STK11, TP53*
High/Moderate Risk Breast Cancer Panel	*ATM, BRCA1, BRCA2, CDH1, CHEK2, PALB2, PTEN, STK11, TP53*
GYN Cancer Panel	*BRCA1, BRCA2, CHEK2, EPCAM, MLH1, MSH2, MSH6, MUTYH, PMS2, PTEN, TP53*
Breast and GYN Cancer Panel	*ATM, BARD1, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, EPCAM, FAM175A, MRE11A, FANCC, MLH1, MSH2, MSH6, MUTYH, NBN, NF1, PALB2, PMS2, PTEN, RAD50, RAD51C, RAD51D, STK11, TP53*
High Risk Colorectal Cancer Panel	*APC, EPCAM, MLH1, MSH2, MSH6, MUTYH, PMS2*
Colorectal Cancer Panel	*APC, ATM, AXIN2, BLM, BMPR1A, BRCA1, BRCA2, CDH1, CDK2A, CHEK2, EPCAM, MLH1, MSH2, MSH6, MUTYH, PMS2 POLD1, POLE, PTEN, SMAD4, STK11, TP53*
Brain/CNS/PNS Cancer Panel	*ALK, APC, MEN1, MLH1, MSH2, MSH6, NBN, NF1, NF2, PHOX2B, PMS2, PTCH1, RB1, SMARCB1, SUFU, TP53, VHL*
Endocrine Cancer Panel	*CDC73, MAX, MEN1, NF1, PRKAR1A, PTEN, RET, SDHB, SDHC, SDHD, TMEM127, TP53, VHL*
Pancreatic Cancer Panel	*APC, ATM, BRCA1, BRCA2, CDKN2A, EPCAM, MLH1, MSH2, MSH6, PALB2, PMS2, STK11, TP53, VHL*
Renal Cell Cancer Panel	*EPCAM, FH, FLCN, GPC3, MET, MITF, MLH1, MSH2, MSH6, PMS2, PTEN, SDHB, SDHC, SDHD, TP53, TSC1, TSC2, VHL, WT1*
Lynch Syndrome Panel	*MLH1, MSH2, MSH6, PMS2, EPCAM*
Prostate Cancer Panel	*ATM, BRCA1, BRCA2, CHEK2, HOXB13, MLH1, MSH2, MSH6, PALB2, PMS2*

BRCAssure® Test Components

Comprehensive Analysis	**BRCA1 Target Analysis**	**BRCA2 Target Analysis**	**Ashkenazi Jewish Panel**
Includes full gene sequencing and deletion/duplication analysis of BRCA1/2 genes	Includes sequencing of known familial mutation(s) on BRCA1 gene	Includes sequencing of known familial mutation(s) on BRCA2 gene	Includes screening for three known pathogenic variants: two in BRCA1 gene, and one in BRCA2 gene

Lynch Syndrome Germline Testing - Individual Test List (Test Names / Test Code)

Single Gene Tests

MLH1 Deletion/Duplication Analysis (511690)
MSH2 Deletion/Duplication Analysis (511705)
MSH6 Deletion/Duplication Analysis (511720)
PMS2 Deletion/Duplication Analysis (511725)

Familial Tests with Known Mutations▲

MLH1 (511635)
MSH2 (511750)
MSH6 (511765)
PMS2 (511776)
EPCAM Deletion/Duplication Analysis (511654)

▲ Please attach a copy of family member's test results

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

Symbols Legend
 # = Medicare deems investigational. Medicare does not pay for services it deems investigational.

Refer to Determining Necessity of ABN Completion.

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.

onc-872-v10-11/10/2021