

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 <input type="checkbox"/> 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
CLINICAL/SPECIMEN INFORMATION	
Collection Date:	Time: Fixative: <input type="checkbox"/> 10% Neutral Buffered Formalin
Send Date:	<input type="checkbox"/> Other:
Required for Breast Cancer: Time to Fixation:	Hours Fixed:
Body Site/Descriptor:	<input type="checkbox"/> See previous case history
Specimen ID# (as it appears on the specimen):	
Narrative Diagnosis/Clinical Data (Please provide pathology report):	
<input type="checkbox"/> Paraffin Block(s): # _____ <input type="checkbox"/> Choose best block (default) <input type="checkbox"/> Slides: # _____ <input type="checkbox"/> Smears: # _____ <input type="checkbox"/> Perform tests on all blocks <input type="checkbox"/> Plasma: _____ <input type="checkbox"/> Other: _____	
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:
CLINICAL INDICATION (attach clinical history and pathology reports)	
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	ICD-CM

TESTING REQUESTED	
IMMUNOHISTOCHEMISTRY LEVEL OF SERVICE – MUST SELECT ONE	
<input type="checkbox"/> IHC stain with Manual Interpretation <input type="checkbox"/> IHC stain with Quantitative Image Analysis (Global; Breast only) <input type="checkbox"/> IHC stain - Technical Component only (slides) <input type="checkbox"/> IHC stain with Virtual Image - Technical Component only	
BREAST CANCER	
HER2 requires formalin-fixed tissue; equivocal IHC results (2+) will be reflexed to FISH	
<b>Panels:</b> <input type="checkbox"/> ER*, PR* <input type="checkbox"/> ER*, PR*, HER2 (IHC)* <input type="checkbox"/> ER*, PR*, HER2 (IHC)*, Ki-67* <input type="checkbox"/> ER*, PR*, HER2 (FISH) <input type="checkbox"/> ER*, PR*, HER2 (FISH), Ki-67*	<b>Reflex Options:</b> <input type="checkbox"/> HER2 (FISH); if Group 2,3 or 4, reflex to IHC <input type="checkbox"/> ER, PR, HER2 IHC (w/2+ reflex to HER2 FISH), if all negative, reflex to PD-L1 22C3 (KEYTRUDA®)IHC ¥ <input type="checkbox"/> ER, PR, HER2 (FISH), if all 3 negative, reflex to PD-L1 22C3 (KEYTRUDA®)IHC ¥
<b>Individual Tests:</b> <input type="checkbox"/> ER* <input type="checkbox"/> p53* <input type="checkbox"/> PIK3CA mutation analysis, IVD <input type="checkbox"/> PR* <input type="checkbox"/> DNA ploidy <input type="checkbox"/> Tamoxifen CYP2D6 Genotype <input type="checkbox"/> HER2 (IHC)* <input type="checkbox"/> E-Cadherin <input type="checkbox"/> Ki-67* <input type="checkbox"/> PD-L1 22C3 (KEYTRUDA®) IHC ¥ for TNBC <input type="checkbox"/> HER2 (FISH)	
<input type="checkbox"/> Prosigna® Breast Cancer Prognostic Gene Signature Assay <input type="checkbox"/> ER, PR, HER2 (IHC); if ER/PR+ HER2-, reflex to Prosigna® <b>REQUIRED FOR PROSIGNA®:</b> Gross Tumor Size (must select one) <input type="checkbox"/> ≤ 2 cm <input type="checkbox"/> > 2 cm Nodal Status (must select one) <input type="checkbox"/> Negative <input type="checkbox"/> 1-3 nodes	
COLORECTAL CANCER	
<b>Panels:</b> <input type="checkbox"/> Comprehensive CRC Predictive Panel (Extended KRAS/NRAS, BRAF, MSI) <input type="checkbox"/> Extended RAS/RAF Pathway Mutation Panel (KRAS, NRAS, BRAF) <input type="checkbox"/> Extended RAS Pathway Mutation Panel (KRAS, NRAS)	<b>Panels for Lynch Syndrome:</b> <input type="checkbox"/> Lynch Syndrome Comprehensive Tumor Evaluation® <input type="checkbox"/> MLH1/MSH2/MSH6/PMS2 (MMR IHC) <input type="checkbox"/> Reflex to MSI (PCR) if any IHC marker listed above is not expressed <input type="checkbox"/> Reflex to BRAF if MLH1 is not expressed (Colorectal cancer only)
<b>Individual Tests:</b> <input type="checkbox"/> KRAS extended mutation (exons 2, 3, 4)* <input type="checkbox"/> KRAS mutation, IVD (codons 12,13) <input type="checkbox"/> NRAS extended mutation (exons 2, 3, 4)* <input type="checkbox"/> BRAF mutation <input type="checkbox"/> EGFR (FISH) <input type="checkbox"/> UGT1A1* <input type="checkbox"/> HER2 (IHC) (with reflex to FISH if equivocal)	
MSI by PCR: To note, tumor <b>and</b> normal tissue/peripheral blood required for MSI (PCR) <input type="checkbox"/> If insufficient normal tissue submitted, perform MMR by IHC	
NON-SMALL CELL LUNG CANCER	
<b>Panels:</b> <input type="checkbox"/> Comprehensive NSCLC Predictive Panel ([EGFR, KRAS, BRAF mutation analysis], [ALK, ROS1, RET by FISH], PD-L1 KEYTRUDA® by IHC¥)	
<b>Reflex Options:</b> <input type="checkbox"/> EGFR mutation; if result wild-type, reflex to: <input type="checkbox"/> KRAS <input type="checkbox"/> ALK (FISH) <input type="checkbox"/> ROS1 <input type="checkbox"/> RET <input type="checkbox"/> EGFR mutation and ALK; if results wild-type/negative, reflex to: <input type="checkbox"/> ROS1 <input type="checkbox"/> RET <input type="checkbox"/> KRAS	
<b>Individual Tests:</b> <input type="checkbox"/> EGFR mutation analysis <input type="checkbox"/> ROS1 (FISH) <input type="checkbox"/> ALK (D5F3) (IHC) <input type="checkbox"/> KRAS mutation analysis <input type="checkbox"/> RET (FISH) <input type="checkbox"/> EGFR mutation test, IVD (cobas®v2) <input type="checkbox"/> BRAF mutation analysis <input type="checkbox"/> cMET (FISH) <input type="checkbox"/> KRAS mutation test, IVD (codons 12,13) <input type="checkbox"/> ALK (FISH) <input type="checkbox"/> EGFR (FISH)	
IMMUNOTHERAPY	
Provide Pathology Report	
<b>Mismatch repair deficient tumors (any solid tumor)</b> <input type="checkbox"/> MMR IHC (MLH1/MSH2/MSH6/PMS2) <input type="checkbox"/> MSI <b>PD-L1 (IHC) (Tumor types listed per FDA-approved kit package insert)</b> PD-L1 22C3 (KEYTRUDA®) - Global <input type="checkbox"/> NSCLC* <input type="checkbox"/> Cervical <input type="checkbox"/> Esophageal (Squamous cell only) <input type="checkbox"/> SCC of the head and neck <input type="checkbox"/> Triple-negative breast cancer (TNBC) <input type="checkbox"/> Gastric/GEJ PD-L1 28-8 (OPDIVO®) - Global <input type="checkbox"/> NSCLC <input type="checkbox"/> SCC of the head and neck <input type="checkbox"/> Urothelial carcinoma PD-L1 SP263 (TECENTRIQ®) - Global <input type="checkbox"/> NSCLC*#	
<input type="checkbox"/> PD-L1 KEYTRUDA Tech Only (88360-TC) <input type="checkbox"/> PD-L1 OPDIVO Tech Only (88360-TC) <input type="checkbox"/> PD-L1 SP263TECENTRIQ Tech Only (88360-TC)	
GASTRIC CANCER	
Equivocal HER2 IHC results (2+) will be reflexed to FISH	
<input type="checkbox"/> HER2 (FISH) & HER2 (IHC) <input type="checkbox"/> HER2 (IHC) <input type="checkbox"/> HER2 (FISH) <input type="checkbox"/> Claudin 18 (IHC)	
TESTS FOR OTHER CANCERS	
Melanoma: <input type="checkbox"/> BRAF mutation analysis (V600) <input type="checkbox"/> LAG-3 by IHC ¥ Ovarian: <input type="checkbox"/> FOLR1 by IHC GIST: <input type="checkbox"/> cKIT mutation analysis <input type="checkbox"/> PDGFRA mutation analysis Glioblastoma: <input type="checkbox"/> 1p19q deletions (FISH) <input type="checkbox"/> MGMT methylation <input type="checkbox"/> IDH1/IDH2 mutation analysis <input type="checkbox"/> TERT promoter mutation assay Thyroid: <input type="checkbox"/> BRAF mutation analysis Pan-tumor: <input type="checkbox"/> PD-L1 quantitative by IHC <input type="checkbox"/> pan-TRK by IHC (NTRK) <input type="checkbox"/> BRAF mutation analysis (V600) <input type="checkbox"/> HER2 by IHC, Pan-tumor	
<b>Additional tests:</b> (Please visit <a href="http://www.oncology.labcorp.com">www.oncology.labcorp.com</a> to see a complete list of our testing services)	

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.

\*Lynch Syndrome Comprehensive Tumor Evaluation includes MLH1/MSH2/MSH6/PMS2 (IHC), and MSI (PCR). If MLH1 is deficient, reflex to BRAF mutation analysis. If negative, reflex to MLH1^ promoter methylation. If ordering for endometrial cancer, BRAF mutation analysis will not be performed.

\*Peripheral blood only \*Investigational use only \*Antibodies can be available by quantitative image analysis  
 ¥ This test can also be used for LIBTAVO® eligibility ¥ Global Only  
 ^ PD-L1 SP263 CDx indication for early stage II-III NSCLC

## 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](http://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 on reverse.

Symbols Legend

@ = Subject to Medicare medical necessity guidelines

^ = Medicare deems investigational. Medicare does not pay for services it deems investigational.

### ★Codons included in Colorectal Cancer Mutation Testing:

KRAS/NRAS

Exon 2 Codons 12 and 13

Exon 3 Codons 59 and 61

Exon 4 Codons 117 and 146