

OncoBEAM™ TEST REQUISITION FORM

1. PATIENT INFORMATION

PATIENT NAME (First, MI, Last) _____ FEMALE
 MALE

PATIENT ID (e.g. MRN, SSN) _____ / /
 DOB (MM/DD/YYYY) _____

ADDRESS _____ PHONE # _____

CITY _____ STATE _____ ZIP _____

2. BILLING INFORMATION

BILL TO: MEDICARE INSURANCE CLIENT PATIENT

INSURANCE NAME _____

PATIENT STATUS: HOSPITAL INPATIENT HOSPITAL OUTPATIENT
 NON-HOSPITAL PATIENT

POLICY # _____ GROUP _____ / /
 POLICY HOLDER NAME _____ DOB (MM/DD/YYYY) _____

RELATIONSHIP TO POLICY HOLDER: SELF SPOUSE
 CHILD OTHER REFERRAL #: _____

ADDRESS _____ PHONE # _____

CITY _____ STATE _____ ZIP _____

SECONDARY INSURANCE _____

Attach Photocopy of Insurance Card (Front and Back)

3. SPECIMEN INFORMATION

2 BLOOD STRECK BCT tubes **10 mL IMPORTANT** – must be shipped within 24 hours of blood draw (**preferred option**)

_____ / / : _____ AM
 COLLECTION DATE (MM/DD/YYYY) COLLECTION TIME PM

NUMBER OF TUBES _____ ESTIMATED VOLUME _____ SPECIMEN ID _____

Clinical Data

ICD-10 Code(s): _____

Clinical Indication: (Please check at least one)

Insufficient tissue Biopsy at progression Other: _____

Rapid results required Invasive biopsy risk

For specimen shipments call FedEx at 1-800-GO-FEDEX (1-800-463-3339).

4. REQUESTING PHYSICIAN

NAME (First, MI, Last) _____

NPI # _____

OFFICE/HOSPITAL NAME _____

SYSTEMX INOSTICS, INC. ACCOUNT # (If unknown please complete address) _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

CONTACT NAME _____

PHONE _____ FAX _____

EMAIL (for follow-up) _____

5. TESTS (SELECT UP TO TWO)

Colorectal Cancer*

OncoBEAM™ CRC1: KRAS, NRAS, BRAF (LT019)

Lung Cancer*

OncoBEAM™ Lung1: EGFR (including T790M) (LT032)

OncoBEAM™ Lung2: EGFR, KRAS, BRAF (LT031)

Melanoma*

OncoBEAM™ Melanoma1: BRAF, NRAS (LT025)

OncoBEAM™ Melanoma2: BRAF (LT026)

** See reverse for additional details*

Acknowledgement:

I authorize Systemx Inostics, Inc. to provide the information on this form and any other information necessary to my health insurance for the testing services ordered by my healthcare provider that may be denied by my insurance.

I authorize Systemx Inostics to retain and use my de-identified specimen and test data for research and/or to help develop new products or services, in compliance with applicable laws. All information that could link me to the specimen or data will be removed.

I do not authorize Systemx Inostics to retain and use my de-identified specimen and test data as described above.

If signature is present but box is not checked, consent is implied. All leftover specimens from New York State will be destroyed within 60 days

Patient Signature

Patient Name

6. STATEMENT OF MEDICAL NECESSITY

I have supplied information to the patient regarding OncoBEAM™ testing and the patient has given consent for the said testing to be performed. I further confirm that this test is medically necessary for the diagnosis or detection of a medical condition and the results will be used in the medical management and treatment decisions for the patient. I authorize Systemx Inostics to submit insurance claims and appeal any denied charges on behalf of my patient using information supplied on this form and agree to support these claims with additional information as necessary. I confirm that the person listed in the Submitting Physician space above is authorized by law to order the test(s) requested herein.

Requesting Physician Signature Date (MM/DD/YYYY)

TESTS (ADDITIONAL DETAILS)

Colorectal Cancer*

• **OncoBEAM™ CRC1:**

KRAS (G12S, G12R, G12C, G12D, G12A, G12V, G13D, A59T, Q61L, Q61H**, K117N**, A146T, A146V)

NRAS (G12S, G12R, G12C, G12D, G12A, G12V, G13R, G13D, G13V, A59T, Q61L, Q61H**, Q61K, Q61R, K117N**, A146T)

BRAF (V600E)

Melanoma*

• **OncoBEAM™ Melanoma1:**

BRAF (V600E, V600K)

NRAS (Q61K, Q61R, Q61L, Q61H**)

• **OncoBEAM™ Melanoma2:**

BRAF (V600E, V600K)

** includes 2 mutations

Lung Cancer*

• **OncoBEAM™ Lung1:**

EGFR (T790M, L858R, L861Q, E746_S752>V, L747_A750>P, L747_T751del, L747_P753>S, E746_A750del**, C797S**)

• **OncoBEAM™ Lung2:**

EGFR (T790M, L858R, L861Q, E746_S752>V, L747_A750>P, L747_T751del, L747_P753>S, E746_A750del**, C797S**)

KRAS (G12S, G12R, G12C, G12D, G12A, G12V, G13D, Q61L, Q61H**)

BRAF (V600E)

RETURN THIS TEST REQUISITION FORM TO SYSMEX INOSTICS, INC. IN THE SAME SHIPMENT AS THE SPECIMEN

SYSMEX INOSTICS, INC. USE ONLY				Barcode/Accession ID's	
RECEIVED DATE:	/	/	<input type="checkbox"/> AM	TIME:	:
			<input type="checkbox"/> PM	INITIALS:	TEMP:
					°C
ACCESSION DATE:	/	/	INITIALS 1:	INITIALS 2:	COMMENTS/CONDITION:

*OncoBEAM™ tests were developed and their performance characteristics determined by Sysmex Inostics. Sysmex Inostics Inc. is regulated under the Clinical Laboratory Improvement Amendments of 1988 as qualified to perform high complexity testing (CLIA ID 21D2048813). OncoBEAM™ tests have not been cleared or approved by the US Food and Drug Administration (FDA).