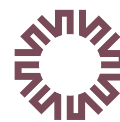
Acct:



Sonora Quest Laboratories™

A Subsidiary of Laboratory Sciences of Arizona

800.766.6721 www.SonoraQuest.com

Hereditary Cancer Test Requisition

P: F:

DATE COLLECTED / /

FAX (verify #)

SEX ☐ M ☐ F

COLL TIME AM PM

DATE OF BIRTH / /

PLEASE PRINT CLEARLY ALL INFORMATION MUST BE PROVIDED OR ACCOUNT WILL BE BILLED. USE BLACK OR BLUE INK ONLY

PATIENT'S LAST NAME FIRST MI

CLINICAL INFO.

CHART/ OTHER I.D.

* All testing is subject to Medicare and Payor medical necessity criteria and policies. Provide a signed ABN or AWN if this criteria is not met.

PAT. SS# (Will not print on report)

ORDERING PHYSICIAN & NPI REQUIRED (Unless listed and circled above):

ICD-10 CODES:

BILL: ☐ ACCOUNT COMPLETE YELLOW AREAS | ☐ PATIENT ☐ PAID AT PSC (RECEIPT ATTACHED) COMPLETE YELLOW & GREY AREAS | ☐ INSURANCE (INFO MUST MATCH INSURANCE CARD) COMPLETE YELLOW, GREY & GREEN AREAS | ☐ MEDICARE COMPLETE YELLOW, GREY, GREEN AREAS & ATTACH ABN IF NECESSARY *

RESPONSIBLE PARTY/INSURED:

ADDRESS:

CITY / STATE / ZIP CODE: PT. RELATIONSHIP:

HOME PHONE NO.: WORK PHONE NO.:

REPORT COPY TO INCLUDE NAME, ACCT. # AND ADDRESS:

INSURANCE COMPANY/UNDERWRITER/CARRIER:

CLAIMS ADDRESS:

CITY / STATE / ZIP CODE: EMPLOYER:

INSURANCE PLAN NAME/ADMINISTRATOR: GROUP/PLAN #:

INSURANCE I.D. #:

Breast Cancer Risk (circle selection)

906369 BRCA Panel *(BRCA1 & BRCA2)*

906366 BRCA Ashkenazi Jewish Screen *(Common founder mutations (BRCA1 c.68_69delAG, BRCA1 c.5266dupC, BRCA2 c.5946delT)*

906474 BRCA Ashkenazi Jewish Screen w/Reflex to BRCA1, BRCA2 *(BRCA Ashkenazi Jewish Screen, if negative reflex to BRCA Panel- BRCA1 and BRCA2)*

906367 BRCA1 & BRCA2 Deletion & Duplication

Colorectal Cancer/Polyposis Risk (circle selection)

906541 Lynch Syndrome Panel *(MLH1, MSH2 (Inc. EPCAM), MSH6, and PMS2)*

907262 Hereditary Colorectal Cancer Panel (19 Genes) *(APC, AXIN2, BMPR1A, CDH1, EPCAM, GREM1, MLH1, MSH2, MSH3, MSH6, MUTYH, NTHL1, PMS2, POLD1, POLE, PTEN, SMAD4, STK11, TP53*

Expanded Hereditary Cancer Risk Panels (circle selection)

907261 Guideline Based Hereditary Cancer Panel (32 Genes) *(APC, ATM, AXIN2, BMPR1A, BRCA1, BRCA2, BRIP1, CDH1, CDK4, CDKN2A (p16, p14), CHEK2, EPCAM, GREM1, HOXB13, MLH1, MSH2, MSH3, MSH6, MUTYH, NBN, NF1, NTHL1, PALB2, PMS2, POLD1, POLE, PTEN, RAD51C, RAD51D, SMAD4, STK11, TP53)*

907263 Comprehensive Hereditary Cancer Panel (66 Genes) *(APC, ATM, AXIN2, BAP1, BARD1, BLM, BMPR1A, BRCA1, BRCA2, BRIP1, CDH1, CDK4, CDKN1B, CDKN2A (p16, p14), CHEK2, DICER1, EGFR, EPCAM, FANCA, FANCC, FANCM, FH, FLCN, GALNT12, GREM1, HOXB13, MAX, MEN1, MET, MITF, MLH1, MRE11 (MRE11A), MSH2, MSH3, MSH6, MUTYH, NBN, NF1, NTHL1, PALB2, PMS2, POLD1, POLE, POT1, PTCH1, PTEN, RAD50, RAD51C, RAD51D, RECQL, RET, SDHA, SDHAF2, SDHB, SDHC, SDHD, SMAD4, SMARCA4, STK11, SUFU, TMEM127, TP53, TSC1, TSC2, VHL, XRCC2)*

Single Site Testing for any gene in the Comprehensive Cancer Panel

907051 Gene Name: ____________________ **Variant Name:** ______________

Copy of family member's report MUST be submitted with order

*** Pre-Authorization is required for all patients ***

☐ Pre-authorization approved ☐ Private Pay - No pre-auth. required

Pre-authorization number: ____________________

Patient Acknowledgement - Required

I authorize Sonora Quest Laboratories and Quest Diagnostics to release information received, including, without limitation, medical information, which includes laboratory test results, which may include genetics test results, to my health plan/insurance carrier and its authorized representatives. I further authorize my health plan/insurance carrier and its authorized representatives as necessary for reimbursement. I further authorize direct payment to Sonora Quest Laboratories for the services rendered.

I understand that testing of my sample will not occur until prior authorization or payment has been received, and that I am financially responsible for portions of this test not covered by my insurer. I agree to help Sonora Quest Laboratories resolve any insurance claim issues.

Patient Signature ____________________ Date ____________

Sonora Quest Laboratories offers insurance pre-authorization concierge services for Hereditary Cancer testing through our parent company Quest Diagnostics. Call 866.GENE.INFO for details and fax this page, the Patient History form, and any other supporting documentation to 855.422.5181. More information and resources for Hereditary Cancer testing and services can be found at www.SonoraQuest.com/HereditaryCancer. Genetic consultations are available for physicians and links to genetic counseling for patients by calling concierge services at 866.GENE.INFO.

A letter of medical necessity is recommended for each patient (except Medicare patients that meet criteria). The letter template can be found at www.SonoraQuest.com/HereditaryCancer and should be sent in with each order to help secure coverage.

A complete Hereditary Cancer Patient & Family Clinical History Form MUST be submitted - see page 2 and submit with this order form

For any patient of any payor (including Medicare and Medicaid), only order those tests which are medically necessary for the diagnosis and treatment of the patient. All reflex testing is performed at an additional charge.

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To avoid testing delays, this form must be completed in its entirety for all orders.

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Hereditary Cancer Clinical History Form

Go to YourHistoryForm.com to complete this form online. If preferred, please complete the form below.

Client Account Number: ______________________ Client Name: ______________________

Patient Name: ______________________ Patient DOB: ______________________ Patient Phone: ______________________

Ethnicity (Please select all that apply)

☐ African American/Black ☐ Native American ☐ Western/Northern European ☐ Middle/Near Eastern ☐ Other: ____________
☐ Hispanic ☐ Asian ☐ Eastern/Central European ☐ Jewish (Ashkenazi)

Genetic Testing History

Has the patient had previous genetic testing associated with hereditary cancer? ☐ Yes ☐ No	If Yes for any question, a copy of the patient's or family member's genetic test report must be faxed (1.855.422.5181) or emailed to Preauthorization@QuestDiagnostics.com. Please note the family member's relation to the patient on this report.
If yes, what sample type was tested? ☐ Blood/Saliva ☐ Tumor	
Has anyone in the patient's family tested positive for a genetic variant associated with hereditary cancer? ☐ Yes ☐ No	
If Yes, will a sample from the family member that tested positive be provided?[a] ☐ Yes ☐ No	

[a] ACMG guidelines, CAP, and CLIA regulatory provisions recommend use of a positive control.

Patient History (Please check here if no relevant family history) ☐

Bone marrow transplant recipient? ☐ Yes [b] ☐ No Current diagnosis of hematological malignancy? ☐ Yes [b] ☐ No

Lynch syndrome risk model score of ≥2.5% (eg PREMM5)? ☐ Yes ☐ No

Breast cancer risk model score of >5% (eg Tyrer-Cuzick, BRCAPro, or PennII)? ☐ Yes ☐ No

If the patient has no history of cancer, please skip to the next section.

Cancer Type/Location	(Optional: Please check boxes that apply)	Age at Diagnosis
☐ Breast	☐ Bilateral ☐ Premenopausal ☐ Triple Negative (ER-,PR-,HER2-) ☐ Invasive ductal ☐ Invasive lobular ☐ DCIS	
☐ Colon/Rectal	Tumor testing: ☐ MSI-H ☐ Abnormal IHC Features: ☐ MSI High Histology	
☐ Colon/Rectal Polyps	Number: ☐ 0-10 ☐ 11-20 ☐ > 20 Type: ☐ Adenoma ☐ Other ______	
☐ Endometrial/Uterine	Tumor testing: ☐ MSI-H ☐ Abnormal IHC	
☐ Ovarian (peritoneal/fallopian tube)		
☐ Pancreatic	☐ Exocrine ☐ Neuroendocrine	
☐ Prostate	☐ Gleason Score ≥7 ☐ Metastatic ☐ Intraductal	
☐ Other	Type of Cancer:	

[b] If Yes, please call 1.866.GENE.INFO prior to sending a specimen to discuss this order.

Family History (Please check here if no relevant family history) ☐

Relationship to Patient	Maternal	Paternal	Cancer Location (Indicate cancer type and/or associated findings like colon polyps)	Age at Diagnosis	Living or Deceased? (Date of death)
	☐	☐			
	☐	☐			
	☐	☐			
	☐	☐			

For questions, please contact 1.855.509.4909 or email us at Preauthorization@QuestDiagnostics.com.

Continued on next page

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Hereditary Cancer Clinical History Form

Breast Cancer Risk Model Information (Only complete for female patients NEVER diagnosed with breast cancer)

Patient Information:

Height: ft: ________ in: ________ Weight (lbs): ______________

Patient's age at time of first menstrual period: ______________

Is patient currently: ☐ Premenopausal ☐ Perimenopausal
☐ Postmenopausal: Age of postmenopausal onset: ________________

Has this patient had a live birth? ☐ No ☐ Yes — patient's age at first child's birth: __________

Has patient ever used Hormone Replacement Therapy? ☐ Yes ☐ No

If Yes, Treatment Type: ☐ Combined ☐ Estrogen only ☐ Progesterone only

If Yes, is Patient a: ☐ Current User: started ________ years ago
Intended use for ________ more years
☐ Past User: stopped ________ years ago

Information About Patient's Female Relatives:

Number of daughters: ____________

Number of sisters: ____________

Number of maternal aunts (mother's sisters): ____________

Number of paternal aunts (father's sisters): ____________

Please indicate if the patient has had a breast biopsy showing one or more of the following results:

☐ N/A (No biopsy or none of the listed results) ☐ Biopsy with unknown or pending results
☐ Hyperplasia ☐ Atypical Hyperplasia ☐ LCIS

Patient Acknowledgement

I authorize Quest Diagnostics (Quest) to release information received, including, without limitation, medical information, which includes laboratory test results, to my health plan/insurance carrier and its authorized representatives as necessary for reimbursement. I further authorize my health plan/insurance carrier to directly pay Quest for the services rendered. I understand that I may be financially responsible for portions of this test not covered by my insurance, and that Quest will contact me prior to test start ONLY if my responsibility for coinsurance, deductible, and/or non-covered service is estimated to be greater than $100. Tests without a signature will NOT be processed.

Patient/Representative Name (Print): ______________________ Date: ____________

Patient/Representative Signature: ______________________

Please fax or email the completed form to 1.855.422.5181 or Preauthorization@QuestDiagnostics.com.
For questions, please contact 1.855.509.4909 or email us at Preauthorization@QuestDiagnostics.com.

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