

TUMOR ANALYSIS REQUISITION

PATIENT INFORMATION (COMPLETE ONE FORM FOR EACH PERSON TESTED)

Patient Last Name _____ Patient First Name _____ MI _____ Date of Birth (MM / DD / YYYY) _____ / _____ / _____
 Address _____ City _____ State _____ ZIP* (required for ClariFind™ testing for clinical trial matching) _____
 Phone _____ Accession # _____ Hospital / Medical Record # _____ Patient discharged from the hospital/facility: Yes No
 Biological Sex: Female Male Unknown Gender identity (if different from left): _____

* If patient ZIP code is not provided for ClariFind testing, Baylor Genetics will defer to the ZIP code of the forwarding institution.

REPORTING RECIPIENTS

Ordering Physician _____ Institution Name _____
 Email (Required for International Clients) _____ Phone _____ Fax _____

ADDITIONAL RECIPIENTS

Name _____ Email _____ Fax _____
 Name _____ Email _____ Fax _____

PAYMENT (FILL OUT ONE OF THE OPTIONS BELOW)

SELF PAYMENT
 Pay With Sample Bill To Patient
 INSTITUTIONAL BILLING

Institution Name _____ Institution Code _____ Institution Contact Name _____ Institution Phone _____ Institution Contact Email _____

INSURANCE
 Do Not Perform Test Until Patient is Aware of Out-Of-Pocket Costs (excludes prenatal testing)
REQUIRED ITEMS 1. Copy of the Front/Back of Insurance Card(s) 2. ICD10 Diagnosis Code(s) 3. Name of Ordering Physician 4. Insured Signature of Authorization

Name of Insured _____	Insured Date of Birth (MM / DD / YYYY) _____ / _____ / _____	Name of Insured _____	Insured Date of Birth (MM / DD / YYYY) _____ / _____ / _____
Patient's Relationship to Insured _____	Phone of Insured _____	Patient's Relationship to Insured _____	Phone of Insured _____
Address of Insured _____		Address of Insured _____	
City _____	State _____ ZIP _____	City _____	State _____ ZIP _____
Primary Insurance Co. Name _____	Primary Insurance Co. Phone _____	Secondary Insurance Co. Name _____	Secondary Insurance Co. Phone _____
Primary Member Policy # _____	Primary Member Group # _____	Secondary Member Policy # _____	Secondary Member Group # _____

By signing below, I hereby authorize Baylor Genetics to provide my insurance carrier any information necessary, including test results, for processing my insurance claim. I understand that I am responsible for any co-pay, co-insurance, and unmet deductible that the insurance policy dictates, as well as any amounts not paid by my insurance carrier for reasons including, but not limited to, non-covered and non-authorized services. I understand that I am responsible for sending Baylor Genetics any and all payments that I receive directly from my insurance company in payment for this test. Please note that Medicare does not cover routine screening tests.

Patient's Printed Name _____ Patient's Signature _____ Date (MM / DD / YYYY) _____ / _____ / _____

STATEMENT OF MEDICAL NECESSITY (REQUIRED)

This test is medically necessary for the risk assessment, diagnosis, or detection of a disease, illness, impairment, symptom, syndrome, or disorder. The results will determine my patient's medical management and treatment decisions. The person listed as the Ordering Physician is authorized by law to order the test(s) requested herein. I confirm that I have provided genetic testing information to the patient and they have consented to genetic testing.

Physician's Printed Name _____ Physician's Signature _____ Date (MM / DD / YYYY) _____ / _____ / _____



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ETHNICITY

- | | | |
|--|---|---|
| <input type="radio"/> African American | <input type="radio"/> Hispanic American | <input type="radio"/> Pacific Islander (Philippines, Micronesia, Malaysia, Indonesia) |
| <input type="radio"/> Ashkenazi Jewish | <input type="radio"/> Mennonite | <input type="radio"/> South Asian (India, Pakistan) |
| <input type="radio"/> East Asian (China, Japan, Korea) | <input type="radio"/> Middle Eastern (Saudi Arabia, Qatar, Iraq, Turkey) | <input type="radio"/> Southeast Asian (Vietnam, Cambodia, Thailand) |
| <input type="radio"/> Finnish | <input type="radio"/> Native American | <input type="radio"/> Southern European Caucasian (Spain, Italy, Greece) |
| <input type="radio"/> French Canadian | <input type="radio"/> Northern European Caucasian (Scandinavian, UK, Germany) | <input type="radio"/> Other (Specify): _____ |

SAMPLE INFORMATION

Date of Collection (MM / DD / YYYY) _____ Time of Collection _____

NOTE: Extracted DNA/RNA will only be accepted if the isolation of nucleic acids for clinical testing occurs in a CLIA-certified laboratory or a laboratory meeting equivalent requirements as determined by the CAP and/or the CMS.

REQUIRED FOR BREAST CANCER FFPE SAMPLES

Method of Fixation _____ Time to Tissue Fixation _____ Tissue Fixation Time _____

SAMPLE TYPE (PLEASE REFER TO PAGE 5 FOR SAMPLE REQUIREMENTS)

- | | | |
|---|--|---|
| <input type="radio"/> Blood in EDTA Tube (Purple-Top) + | <input type="radio"/> FFPE - Slides * #: _____ | <input type="radio"/> DNA (Concentration) + ±*: _____ |
| <input type="radio"/> Blood in Sodium Heparin (Green-Top) + | <input type="radio"/> FFPE - Tissue Block * | <input type="radio"/> RNA (Concentration) + ±*: _____ |
| <input type="radio"/> Bone Marrow in Sodium Heparin (Green-Top) + | <input type="radio"/> Fresh Frozen Tissue ±* | <input type="radio"/> Other **: _____ |
| <input type="radio"/> Bone Marrow in EDTA (Purple-Top) + | <input type="radio"/> Tissue in Medium ±* | |

+ For hematologic samples, attach clinical notes and concurrent laboratory reports (such as CBC, flow cytometry results, and pathology reports). Concurrent laboratory reports may be sent later as soon as available.
* Surgical Pathology report MUST be attached for all tissue samples but may be sent later as soon as it becomes available.
** Please call for consultation before ordering test.
* Please send a corresponding representative H+E slide, if available.

Gender of Bone Marrow Transplant Donor (select one): Female Male

INDICATION FOR TESTING (REQUIRED)

Indication(s) _____

ICD10 Diagnosis Code(s) _____

RETURN OF FFPE SPECIMENS

Check if block and/or H&E stained slide should be returned. Fill out the return address information below, or affix preprinted label.

This section will be used as the return address label.

Institution _____ ATTN _____
Address _____
City _____ State _____ ZIP _____

SPECIMEN RETRIEVAL

I want Baylor Genetics to request the specimen. (Complete information below)

Location of Specimen _____
Contact Name _____
Phone # _____ Fax # _____



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TUMOR PROFILING BY NEXT-GENERATION SEQUENCING

BE = Blood in EDTA (purple-top) **BME** = Bone Marrow in EDTA (purple-top) **TM** = Tissue in Medium **SA** = Saliva
FFPE = Slides/Block **T** = Fresh Frozen Tissue **DNA** = DNA, Extracted

TEST CODE	TEST NAME	SAMPLE TYPE	SPECIAL NOTES
<input type="checkbox"/> 20010	ClariFind™ Comprehensive DNA Panel	BE, BME, FFPE, T, TM, DNA	DNA coverage for all coding (exonic) regions of 277 key cancer genes for both solid tumors and hematologic malignancies. For further details, please visit baylorgenetics.com/ClariFind.

ADDITIONAL TESTING RECOMMENDATIONS

TEST CODE	TEST NAME	SAMPLE TYPE	DISEASE	SPECIAL NOTES
<input type="checkbox"/> 9505	180K CGH/SNP Array	BE, BME, FFPE, T	Solid Tumors	180K CGH/SNP Array should be considered for genomic copy number analysis. For FFPE slides, please send additional 20 slides.
<input type="checkbox"/> 9150	Microsatellite Instability (MSI), HNPCC/Lynch Syndrome, by PCR	FFPE		Please submit BOTH a source of tumor tissue (FFPE block/slides) AND a source of normal tissue (FFPE block/slides). Testing will be sent to ARUP Laboratories for analysis and reporting.
<input type="checkbox"/> 8030	ALK Rearrangement	FFPE	Non-Small Cell Lung Cancer	FISH testing for ALK, MET, RET, and ROS1 should be considered if not previously performed. For FFPE slides, please send additional 3-5 slides per probe.
<input type="checkbox"/> 8095	MET Amplification	FFPE		
<input type="checkbox"/> 8031	RET Rearrangement	FFPE		
<input type="checkbox"/> 8781	ROS1 Rearrangement	FFPE		
<input type="checkbox"/> 8025	ERBB2 (HER2/neu)	FFPE	Breast Cancer or Gastric Cancer	FISH testing for HER2 should be considered as clinically appropriate and if HER2 testing (immunohistochemistry and/or FISH) not previously performed. For FFPE slides, please send additional 3-5 slides.
<input type="checkbox"/> 8300	Classical Chromosome Analysis - Hematologic Cancer	BH, BMH		Classical chromosomal analysis and appropriate FISH studies should be considered if not previously performed (please also see next page).
<input type="checkbox"/> 9045	FLT3 Mutation Detection by PCR	BE, BME	Hematologic Malignancies	FLT3 mutation testing by PCR should be considered for acute myeloid leukemia. FLT3 testing will be sent to LabPMM for analysis and reporting.
<input type="checkbox"/> 9515	CytoScan HD SNP Array	BE, BME, T		CytoScan HD SNP Array should be considered for genomic copy number analysis.
<input type="checkbox"/> 8760	MYC Translocation	BH, BMH, FFPE	Aggressive/ High-Grade B-Cell Lymphoma	FISH testing for MYC, IGH/BCL2, and BCL6 should be considered if not previously performed. For FFPE slides, please send additional 3-5 slides per probe.
<input type="checkbox"/> 8765	IGH/BCL2: t(14;18)	BH, BMH, FFPE		
<input type="checkbox"/> 8775	BCL6 Rearrangement	BH, BMH, FFPE		

TEST CODE	GENE (REQUIRED)	VARIANT (REQUIRED)	SAMPLE TYPE	DISEASE	SPECIAL NOTES
<input type="checkbox"/> 1566	Custom Sequence Analysis - Variant 1	_____	BE, DNA, SA, TM	Germline	These tests can only be requested on a germline sample for patients with previous variant(s) detected by ClariFind. Complete one test code request for EACH variant. If more than 3 variants are desired, please contact a Baylor Genetics representative at 1.800.411.4363. Please provide the lab number listed on the top of the ClariFind report here:
<input type="checkbox"/> 1567	Custom Sequence Analysis - Variant 2	_____			
<input type="checkbox"/> 1568	Custom Sequence Analysis - Variant 3	_____			

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CANCER MOLECULAR ANALYSIS

BE = Blood in EDTA (purple-top) **BME** = Bone Marrow in EDTA (purple-top)
FFPE = Slides/Block **T** = Fresh Frozen Tissue
NOTE: For Molecular Tests, Bone Marrow and Blood are REQUIRED to be collected in EDTA (PURPLE-TOP) TUBES

CHROMOSOMAL MICROARRAY

TEST CODE	TEST NAME	SAMPLE TYPE
<input type="checkbox"/> 9515	CytoScan HD SNP Array (for Hematologic Malignancies)	BE, BME, T
<input type="checkbox"/> 9505	180K CGH/SNP Array (for Solid Tumors) ¹	BE, BME, FFPE, T

SINGLE GENE TESTING

All single gene tests will be sent out to ARUP Laboratories for analysis and reporting unless otherwise noted.

TEST CODE	TEST NAME	SAMPLE TYPE
<input type="checkbox"/> 9202	B-Cell Clonality Screening (IgH and IgK) by PCR	BE, BME, FFPE, T
<input type="checkbox"/> 9065	<i>BCR-ABL1</i> , Major (p210), Quantitative	BE, BME
<input type="checkbox"/> 9070	<i>BCR-ABL1</i> , Qualitative Analysis w/ Reflex to <i>BCR-ABL1</i> Quantitative	BE, BME
<input type="checkbox"/> 9305	<i>BCR-ABL1</i> Mutation Analysis for Tyrosine Kinase Inhibitor Resistance by NGS	BE, BME
<input type="checkbox"/> 9003	<i>BRAF</i> V600 Mutation Analysis	BE, BME, FFPE
<input type="checkbox"/> 9016	<i>CALR</i> (Calreticulin) Exon 9 Mutation Analysis by PCR	BE, BME
<input type="checkbox"/> 9086	<i>CEBPA</i> Mutation Detection	BE, BME
<input type="checkbox"/> 9030	<i>EGFR</i> Mutation Detection by Pyrosequencing	FFPE
<input type="checkbox"/> 9045	<i>FLT3</i> Mutation Detection by PCR ²	BE, BME
<input type="checkbox"/> 9104	Gastrointestinal Stromal Tumor Mutation (<i>KIT</i> , <i>PDGFRA</i>)	FFPE
<input type="checkbox"/> 9060	<i>IGHV</i> Mutation Analysis by Sequencing	BE, BME
<input type="checkbox"/> 9015	<i>JAK2</i> Exon 12 Mutation Analysis by PCR	BE, BME
<input type="checkbox"/> 9010	<i>JAK2</i> Gene, V617F Mutation, Qualitative	BE, BME
<input type="checkbox"/> 9103	<i>KIT</i> Mutations, Melanoma (including <i>PDGFRA</i>)	FFPE
<input type="checkbox"/> 9105	<i>KIT</i> Mutations in AML by Fragment Analysis and Sequencing	BE, BME
<input type="checkbox"/> 9128	<i>KRAS</i> Mutation Detection	FFPE
<input type="checkbox"/> 9150	Microsatellite Instability (MSI), HNPCC/Lynch Syndrome, by PCR ³	FFPE
<input type="checkbox"/> 9020	<i>MPL</i> Codon 515 Mutation Detection by Pyrosequencing, Quantitative	BE, BME
<input type="checkbox"/> 9005	<i>NPM1</i> Mutation Detection by RT-PCR, Quantitative	BE, BME
<input type="checkbox"/> 9080	<i>PML-RARA</i> Translocation, t(15;17) by RT-PCR, Quantitative	BE, BME
<input type="checkbox"/> 9217	T-Cell Clonality Screening by PCR	BE, BME, FFPE, T
<input type="checkbox"/> 9055	<i>TP53</i> Somatic Mutation, Prognostic	BE, BME, FFPE

REFLEX TESTS

Reflex Request (Please describe below):

¹ For test code 9505: If sending FFPE slides, 20 slides are required for submission.
² For test code 9045: Test will be sent to LabPMM for analysis and reporting.
³ For test code 9150: Please submit BOTH a source of tumor tissue (FFPE block/slides) AND a source of normal tissue (FFPE block/slides).

CYTOGENETIC TESTS

BH = Blood in Sodium Heparin (green-top) **BMH** = Bone Marrow in Sodium Heparin (green-top)
TM = Tissue in Medium **FFPE** = Slides/Block
NOTE: Bone Marrow and Blood are REQUIRED to be collected in SODIUM HEPARIN (GREEN-TOP) TUBES

SINGLE FISH PROBES

TEST CODE	TEST NAME	SAMPLE TYPE
<input type="checkbox"/> 8055	1p/19q Co-deletion	FFPE
<input type="checkbox"/> 8030	ALK Rearrangement	FFPE
<input type="checkbox"/> 8725	AML1/ETO: t(8;21) [AML]	BH, BMH
<input type="checkbox"/> 8775	BCL6 Rearrangement	BH, BMH, FFPE
<input type="checkbox"/> 8750	BCR/ABL: t(9;22) [CML/ALL/AML]	BH, BMH
<input type="checkbox"/> 8740	CBFB: inv(16) [AML]	BH, BMH
<input type="checkbox"/> 8730	CHIC2: Deleted 4q [Hypereosinophilic Syndrome]	BH, BMH
<input type="checkbox"/> 8710	Deletion 5: [MDS]	BH, BMH
<input type="checkbox"/> 8715	Deletion 7: [MDS]	BH, BMH
<input type="checkbox"/> 8720	Deletion 20q12: [MDS]	BH, BMH
<input type="checkbox"/> 8065	DXZ1/DYZ3	BH, BMH
<input type="checkbox"/> 8035	EGFR	FFPE
<input type="checkbox"/> 8025	ERBB2 (HER2/neu)	FFPE
<input type="checkbox"/> 8385	Gain Chromosome 8	BH, BMH
<input type="checkbox"/> 8780	IGH Rearrangement	BH, BMH
<input type="checkbox"/> 8765	IGH/BCL2: t(14;18) [Follicular Lymphoma]	BH, BMH, FFPE
<input type="checkbox"/> 8770	IGH/CCND1: t(11;14) [Mantle Cell Lymphoma]	BH, BMH, FFPE
<input type="checkbox"/> 8095	MET Amplification	FFPE
<input type="checkbox"/> 8745	MLL: 11q23	BH, BMH
<input type="checkbox"/> 8760	MYC translocation	BH, BMH, FFPE
<input type="checkbox"/> 8735	PML/RARA: t(15;17) [AML]	BH, BMH
<input type="checkbox"/> 8031	RET Rearrangement	FFPE
<input type="checkbox"/> 8781	ROS1 Rearrangement	FFPE
<input type="checkbox"/> 8075	SS18 [Synovial Sarcoma]	FFPE
<input type="checkbox"/> 8080	TCF3/PBX1 [ALL]	BH, BMH
<input type="checkbox"/> 8755	TEL/AML1: t(12;21) [ALL]	BH, BMH
<input type="checkbox"/> 8400	OTHER, Probe Name: _____	

CLASSICAL CHROMOSOME ANALYSIS

TEST CODE	TEST NAME	SAMPLE TYPE
<input type="checkbox"/> 8300	Hematologic Cancer	BH, BMH
<input type="checkbox"/> 8050	Solid Tumor	TM

FISH PANELS

TEST CODE	TEST NAME	SAMPLE TYPE
<input type="checkbox"/> 8010	ALL (MYB del, CDKN2A del, BCR/ABL, TEL/AML1, MLL rearrangement, IGH rearrangement)	BH, BMH
<input type="checkbox"/> 8000	AML (Trisomy 8, AML/ETO, MLL rearrangement, PML/RARA, CBFB inversion)	BH, BMH
<input type="checkbox"/> 8040	CLL (MYB del, ATM del, Trisomy 12, 13 del, p53 del, IGH rearrangement)	BH, BMH
<input type="checkbox"/> 8005	MDS (5 del, 7 del, Trisomy 8, MLL rearrangement, 20q del)	BH, BMH
<input type="checkbox"/> 8015	Multiple Myeloma (Trisomy 9, RB1 del, IGH rearrangement, Trisomy 15, p53 del)	BH, BMH
<input type="checkbox"/> 8020	NHL (ALK rearrangement, BCL-6 rearrangement, ATM & p53 del, IGH rearrangement)	BH, BMH



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SAMPLE SPECIFICATIONS TABLE

FOR CLIENT INFORMATION ONLY. Not required with sample submission.

ABBREVIATION	SAMPLE NAME	RECOMMENDED AMOUNT		SHIPPING INSTRUCTIONS	SPECIAL NOTES
		(2 YRS - ADULT)	(NEWBORN - 2YRS)		
BE	Blood in EDTA tube (purple-top)	3 - 5 cc	2 -3 cc	Ship at room or refrigerated temperature in an insulated container by overnight courier. Do not heat or freeze. Specimen should arrive in the laboratory within 24-48 hours of collection.	Attach clinical notes and concurrent laboratory reports (such as CBC, flow cytometry results, and pathology reports). Concurrent laboratory results may be sent later as soon as available.
BH	Blood in Sodium Heparin tube (green-top)	3 - 5 cc	2 -3 cc	Ship at room or refrigerated temperature in an insulated container by overnight courier. Do not heat or freeze. Specimen should arrive in the laboratory within 24-48 hours of collection.	Attach clinical notes and concurrent laboratory reports (such as CBC, flow cytometry results, and pathology reports). Concurrent laboratory results may be sent later as soon as available.
BME	Bone Marrow in EDTA tube (purple-top)	3 - 5 cc	2 -3 cc	Ship at room or refrigerated temperature in an insulated container by overnight courier. Do not heat or freeze. Specimen should arrive in the laboratory within 24-48 hours of collection.	Attach clinical notes and concurrent laboratory reports (such as CBC, flow cytometry results, and pathology reports). Concurrent laboratory results may be sent later as soon as available.
BMH	Bone Marrow in Sodium Heparin tube (green-top)	3 - 5 cc	2 -3 cc	Ship at room or refrigerated temperature in an insulated container by overnight courier. Do not heat or freeze. Specimen should arrive in the laboratory within 24-48 hours of collection.	Attach clinical notes and concurrent laboratory reports (such as CBC, flow cytometry results, and pathology reports). Concurrent laboratory results may be sent later as soon as available. Please send a corresponding representative H+E slide, if available.
DNA	DNA, Extracted	At Least 100 ng	At Least 100 ng	Ship at room or refrigerated temperature in an insulated container by overnight courier. May also be shipped frozen on minimum of 10 lbs of dry ice in an insulated container by overnight courier.	Minimum concentration of 25ng/uL. Attach clinical notes, concurrent laboratory reports, and/or surgical pathology report, as applicable. Please send a corresponding representative H+E slide, if available.
FFPE	FFPE - Block	See Special Notes	See Special Notes	Ship at room temperature in an insulated container by overnight courier. If shipping during the summer months please include a cold-pack to avoid extreme temperatures. Do not heat or freeze.	Paraffin-embedded, formalin-fixed tissue block containing ≥20% tumor nuclei with a minimum tumor surface area of 5mm x 5mm (25mm ²). Decalcified specimens are not accepted. Surgical pathology report must be attached for all tissue samples.
FFPE	FFPE - Slides	See Special Notes	See Special Notes	Ship at room temperature in an insulated container by overnight courier. If shipping during the summer months please include a cold-pack to avoid extreme temperatures. Do not heat or freeze.	10 - 15 unstained 5µm FFPE slides containing ≥20% tumor nuclei with a minimum tumor surface area of 5mm x 5mm (25mm ²). For smaller specimens, 20 or more unstained 5µm FFPE slides containing ≥20% tumor nuclei should be submitted. Decalcified specimens are not accepted. Surgical pathology report must be attached for all tissue samples. For test codes 9505: 20 slides are required for submission.
RNA	RNA, Extracted	At Least 100 ng	At Least 100 ng	Ship frozen on minimum of 10 lbs of dry ice in an insulated container by overnight courier.	Minimum concentration of 25ng/uL. Attach clinical notes, concurrent laboratory reports, and/or surgical pathology report, as applicable. Please send a corresponding representative H+E slide, if available.
SA	Saliva	See Special Notes	See Special Notes	Ship at room temperature in an insulated container by overnight courier. Do not heat or freeze.	Collected with Oragene DNA Self-Collection Kit (provided by Baylor Genetics with instructions).
T	Fresh Frozen Tissue	150 mg	150 mg	Ship frozen on minimum of 10 lbs of dry ice in an insulated container by overnight courier.	Fresh tissue snap frozen at ≤-20°C. Store at ≤-20°C. Surgical pathology report must be attached for all tissue samples. Surgical pathology report may be sent later as soon as it becomes available. Please send a corresponding representative H+E slide, if available.
TM	Fresh Tissue in Medium	0.5 - 1 cm ³ or more	0.5 - 1 cm ³ or more	Ship at room or refrigerated temperature in an insulated container by overnight courier. Do not heat or freeze. Specimen should arrive in the laboratory within 48 hours of collection.	Transport tumor tissue in a sterile, screw-top container filled with tissue culture transport medium. If tissue culture transport medium is not available, collect in plain RPMI, Hanks solution, or saline. Surgical pathology report must be attached for all tissue samples. Surgical pathology report may be sent later as soon as it becomes available. Please send a corresponding representative H+E slide, if available.