

## 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 Code \_\_\_\_\_  
 Phone \_\_\_\_\_ Accession # \_\_\_\_\_ Hospital / Medical Record # \_\_\_\_\_ Patient discharged from the hospital/facility:  Yes  No  
 Biological Sex:  Female  Male  Unknown Gender identity (if different from left): \_\_\_\_\_

### 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

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) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_



## TUMOR ANALYSIS REQUISITION

Patient Last Name \_\_\_\_\_ Patient First Name \_\_\_\_\_ MI \_\_\_\_\_ Date of Birth (MM / DD / YYYY) \_\_\_\_\_ Biological Sex \_\_\_\_\_

### 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, cytogenetics, FISH, molecular testing, 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.

Biological Sex 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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**BH** = Blood in Sodium Heparin (green-top) **BMH** = Bone Marrow in Sodium Heparin (green-top)  
**TM** = Tissue in Medium **FFPE** = Slides/Block

**BE** = Blood in EDTA (purple-top) **BME** = Bone Marrow in EDTA (purple-top)  
**FFPE** = Slides/Block **T** = Fresh Frozen Tissue

### CANCER MOLECULAR ANALYSIS

#### SINGLE GENE TESTING

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 BCR-ABL1, Major (p210), Quantitative	BE, BME
<input type="checkbox"/>	8972 BCR-ABL1, Minor (p190), Quantitative	BE, BME
<input type="checkbox"/>	9070 BCR-ABL1, Qualitative Analysis w/ Reflex to BCR-ABL1 Quantitative <sup>4</sup>	BE, BME
<input type="checkbox"/>	9305 BCR-ABL1 Mutation Analysis for Tyrosine Kinase Inhibitor Resistance by NGS	BE, BME
<input type="checkbox"/>	9003 BRAF V600 Mutation Analysis	BE, BME, FFPE
<input type="checkbox"/>	9016 CALR (Calreticulin) Exon 9 Mutation Analysis by PCR	BE, BME
<input type="checkbox"/>	9086 CEBPA Mutation Detection	BE, BME
<input type="checkbox"/>	9030 EGFR Mutation Detection by Pyrosequencing	FFPE
<input type="checkbox"/>	9045 FLT3 Mutation Detection by PCR <sup>2</sup>	BE, BME
<input type="checkbox"/>	9104 Gastrointestinal Stromal Tumor Mutation (KIT, PDGFRA)	FFPE
<input type="checkbox"/>	9060 IGHV Mutation Analysis by Sequencing	BE, BME
<input type="checkbox"/>	9015 JAK2 Exon 12 Mutation Analysis by PCR	BE, BME
<input type="checkbox"/>	9010 JAK2 Gene, V617F Mutation, Qualitative	BE, BME
<input type="checkbox"/>	8970 KIT (D816V) Mutation by PCR	BE, BME
<input type="checkbox"/>	9103 KIT Mutations, Melanoma (including PDGFRA)	FFPE
<input type="checkbox"/>	9105 KIT Mutations in AML by Fragment Analysis and Sequencing	BE, BME
<input type="checkbox"/>	9128 KRAS Mutation Detection	FFPE
<input type="checkbox"/>	8974 MGMT Methylation Detection by PCR	FFPE
<input type="checkbox"/>	9150 Microsatellite Instability (MSI), HNPCC/Lynch Syndrome, by PCR <sup>3</sup>	FFPE
<input type="checkbox"/>	9020 MPL Codon 515 Mutation Detection by Pyrosequencing, Quantitative	BE, BME
<input type="checkbox"/>	8973 MYD88 L265P Mutation Detection by PCR, Quantitative	BE, BME, FFPE
<input type="checkbox"/>	9005 NPM1 Mutation Detection by RT-PCR, Quantitative	BE, BME
<input type="checkbox"/>	8971 NRAS Mutation Detection by Pyrosequencing	FFPE
<input type="checkbox"/>	8976 PD-L1 28-8 pharmDx by Immunohistochemistry with Interpretation, nivolumab (OPDIVO)	FFPE
<input type="checkbox"/>	8975 PD-L1 22C3 IHC for NSCLC by Immunohistochemistry with Interpretation, pembrolizumab (KEYTRUDA)	FFPE
<input type="checkbox"/>	8977 PD-L1 22C3 IHC with Combined Positive Score (CPS) Interpretation, pembrolizumab (KEYTRUDA)	FFPE
<input type="checkbox"/>	9080 PML-RARA 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 TP53 Somatic Mutation, Prognostic	BE, BME, FFPE

#### REFLEX TESTS

Reflex Request (Please describe below):

<sup>1</sup> For test code 9505: If sending FFPE slides, 20 slides are required for submission.

<sup>2</sup> For test code 9045: Test will be sent to LabPM for analysis and reporting.

<sup>3</sup> For test code 9150: Please submit BOTH a source of tumor tissue (FFPE block/slides) AND a source of normal tissue (FFPE block/slides).

<sup>4</sup> For test code 9070: If BCR-ABL1, Major (p210) is detected, reflex to 9065, and if BCR-ABL1, Minor (p190) is detected, reflex to 8972.

### CYTOGENETIC TESTS

#### SINGLE FISH PROBES

TEST CODE	TEST NAME	SAMPLE TYPE
<input type="checkbox"/>	8030 ALK Rearrangement	FFPE
<input type="checkbox"/>	8725 AML1/ETO: t(8;21) [AML]	BH, BMH
<input type="checkbox"/>	8785 BCL2 Rearrangement	FFPE
<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 CBF3: 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"/>	8770 IGH/CCND1: t(11;14) [Mantle Cell Lymphoma]	BH, BMH, FFPE
<input type="checkbox"/>	8786 MALT1 Lymphoma	BH, BMH
<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"/>	8788 p53	BH, BMH
<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"/>	8789 Aggressive/High-Grade B-Cell Lymphoma (MYC translocation, BCL2 rearrangement, BCL6 rearrangement)	FFPE
<input type="checkbox"/>	8010 ALL Adult (CDKN2A del, BCR/ABL gene fusion, KMT2A rearrangement, IGH rearrangement, Trisomy 4, Trisomy 10)	BH, BMH
<input type="checkbox"/>	8792 ALL Pediatric (BCR/ABL translocation, KMT2A rearrangement, ETV6/RUNX1 translocation, Trisomy 4, Trisomy 10, TCF3/PBX1 amplification/deletion)	BH, BMH
<input type="checkbox"/>	8000 AML (Trisomy 8, AML/ETO, MLL rearrangement, PML/RARA, CBF3 inversion)	BH, BMH
<input type="checkbox"/>	8040 CLL (Trisomy 12, ATM del, p53 del, MYB del, 13q del, IGH rearrangement, IGH/CCND1 fusion)	BH, BMH
<input type="checkbox"/>	8791 Eosinophilia (PDGFRB rearrangement, FGFR1 rearrangement, JAK2 rearrangement, PDGFRA/CHIC2/FIP1L1 rearrangement, CBF3 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, Trisomy 7, CKS1B/CDKN2C amplification/deletion)	BH, BMH
<input type="checkbox"/>	<input type="checkbox"/> If IGH rearrangement positive, reflex to 8790	
<input type="checkbox"/>	8790 Multiple Myeloma IgH Rearrangement (IGH/MAF fusion, IGH/FGFR3 fusion, IGH/CCND1 fusion)	BH, BMH
<input type="checkbox"/>	8020 NHL (BCL6 rearrangement, IGH/CCND1 fusion, MYC rearrangement, MALT1 rearrangement, BCL2 rearrangement)	BH, BMH
<input type="checkbox"/>	8787 Non-Small Cell Lung Carcinoma (ALK rearrangement, MET amplification, RET rearrangement, ROS1 rearrangement)	FFPE
<input type="checkbox"/>	8793 NTRK (NTRK1 rearrangement, NTRK2 rearrangement, NTRK3 rearrangement)	FFPE



**TUMOR ANALYSIS REQUISITION**

**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, cytogenetics, FISH, molecular testing, 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, cytogenetics, FISH, molecular testing, 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, cytogenetics, FISH, molecular testing, 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, cytogenetics, FISH, molecular testing, and pathology reports). Concurrent laboratory results may be sent later as soon as 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 <sup>2</sup> ). 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 <sup>2</sup> ). 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 <sup>3</sup> or more	0.5 - 1 cm <sup>3</sup> 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.



