

Clinical Genomics Test Requisition Form - Page 1 of 5 (Exome Sequencing and Microarray)

COMPLETE ENTIRE FORM AND SUBMIT PEDIGREE/CLINIC NOTES TO AVOID DELAYS

To submit an order via email, please send the completed test requisition form to info@ambrygen.com

PATIENT INFORMATION							
Name (Last, First, MI)				Sex at Birth	Date of Birth (MM/DD/	YY)	MRN
				DF DM			
Ethnicity: □ Asian □ Ashkenazi Jew □ Pacific Islander □ Portuguese □ U		an ∏White	☐ French Canadian/Cajun	☐ Hispanic/Lating	D ☐ Mediterranean	□Midd	lle Eastern □Native American
Address			City			State	Zip
Phone		Email				Droform	ed Billing
rhohe		Lillali					rance Self-pay Institutional
SPECIMEN INFORMATION*	For phlebotomy service, select al	ll services you a	are requesting)				
Type(s) Blood (EDTA preferred)	Saliva □Buccal Swab □DI	NA, Source**:	Culture	ed CVS 🔲 Cultured	d amniocytes □Othe	er:	
Personal history of allogenic bone m	narrow or peripheral stem cell	transplant*	Current diagnosis of heme	e malignancy, Type:			
Collection Date	Specimen ID	Send saliva	kit to patient		Medical Re	cord #	
*Blood/saliva/buccal swab sample from hematological disease is not recommend **Fetal specimens, cord blood and POC w sample submission test codes	ed. An alternative specimen ma	y be needed. Se	ee ambrygen.com/specimen-rec	quirements for detail	S.		
Phlebotomy Services Request: Ph ^As the patient's clinician, I am unaware patient if the safety of the phlebotomist c	of any potential for complicatio	n or difficulty i					
ORDERING PHYSICIAN/SEND	DING FACILITY (Each liste	d person will	receive a copy of the report)				
Facility Name (Facility Code)	Address		City		State / Country Z	ip	Phone
Ordering Licensed Provider Name (Last, First)(Code) NPI# Phone			Phone	Fax	Fax/Emai		
ADDITIONAL RESULTS RECIP	IENTS						
Genetic Counselor or Other Medical P	rovider Name (Last, First) (Cc	ode)	Phone/Fax/Email				
CONFIRMATION OF INFORMED CONSENT AND MEDICAL NECESSITY FOR GENETIC TESTING The undersigned person (or representative thereof) ensures he/she is a licensed medical professional authorized to order genetic testing and confirms that the patient has given appropriate consent. I confirm that testing is medically necessary and that test results may impact medical management for the patient. I agree to allow Ambry Genetics to facilitate the provision of pre-test genetic counseling services by a third-party service, as required by the patient's insurance provider. Furthermore, all information on this TRF is true to the best of my knowledge. My signature applies to the attached letter of medical necessity.							
Signature Required for Processing Medical Professional Signature: Date:				ate:			
INSURANCE BILLING (Includ	le copy of both sides of insura	nce card)			INSTITUTIONAL	BILLIN	NG
	Name and DOB of Policy Holder (if not self)			Fac	cility Name	🗆 Send	l invoice to facility address above
Insurance Company	Policy #		HMO Auth #	Ad	dress		
Out of Pocket: Contact Name In many cases, we will start testing immediately (may vary by test or insurance provider). We will attempt to contact the patient if the estimated out-of-pocket costs are > USD \$100. Contact Name							
Special Billing Notes:				Ph	one Number		E-mail/Fax
					PATIENT PAYME		☐ Check (Payable to Ambry Genetics) ☐ Credit Card (Call 949-900-5795)
Patient Acknowledgement: I acknowledge that the information provided by me is true and correct. For direct insurance billing: I authorize my insurance benefits to be paid directly to Ambry Genetics Corporation (Ambry), authorize <u>Ambry</u> to release medical information concerning my testing to my insurer, to be my designated representative for purposes of appealing any denial of benefits as needed and to request additional medical records for this purpose. I understand that I am financially responsible for any amounts not covered by my insurer and responsible for sending Ambry money received from my health insurance company. For patient payment by credit card: I hereby authorize Ambry Genetics Corporation to bill my credit card as indicated above. In order to expedite consideration for eligibility for Ambry's Patient Assistance Program, please provide the total annual gross household income: and the number of family members in the household supported by the listed income: I authorize Ambry Genetics Corporation to verify the above information for the sole purpose of assessing financial need, including the right to seek supporting documentation.							
For NY Residents: I am a New York resident and I give Ambry Genetics permission to store my sample for longer than 60 days. NOTE: If left blank, consent is interpreted as "NO".							
Signature Required For Insurance/Self-Pay Patients and NY Sample Storage Consent: Date:							

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ONLY COMPLETE FOR EXOMENEXT-DUO/TRIO ORDERS OR IF FAMILY MEMBERS WILL BE SUBMITTED FOR CO-SEGREGATION.

All family member specimens must be received within 4 weeks of order. Otherwise test will be run as proband only.

FAMILY MEMBER #1 INFORMATIO)N				
Name (Last, First, MI)		Date of Birth (MM/DD/YY	Date of Death (If applicable)	Phone Number/Email	
	an □Ashkenazi Jewish □Jewisł n □Middle Eastern □Native Ar				☐ Hispanic/Latino
Address: Same as Proband Addres		City	State	Zip	Relationship to proband
SPECIMEN INFORMATION*(For phle	potomy service, select all services you	ı are requesting)			
Type(s) Blood (EDTA preferred)	Saliva DNA, Source:		□Other:		
Personal history of allogenic bone marrow	or peripheral stem cell transplant	Current diagnosis of heme m	nalignancy, Type:		
Collection Date	Specimen ID			Medical Record #	
*Blood/saliva from patients with a history of allo An alternative specimen may be needed. See an	genic bone marrow or stem cell transp	plant cannot be used for genetic tes	ting. Blood/saliva from pati	ents with active hematologica	l disease is not recommended.
Phlebotomy Services Request: Phlebotom	y draw Insurance preverification fi	rst □Send blood kit to patient^□			
^As the patient's clinician, I am unaware of any patient if the safety of the phlebotomist and/or p		in drawing blood for the listed patie	ent(s). I understand that the	phlebotomist has full authori	ty to refuse to draw any
CLINICAL INFORMATION					
Does the family member have any feature	s similar to the proband? 🛛 Yes	s □No □Partially □Pos	ssibly		
Describe:					
SECONDARY FINDINGS					
Secondary findings results are available for	each family member sequenced a	as part of the trio. Check below t	to opt-out of the ACMG	Recommended List of seco	ndary findings. If left
unchecked, secondary findings will be repo					
Opt-out: I choose to decline the ACMG Re		ings.			
FAMILY MEMBER #2 INFORMATI		-) Date of Death (feedings)	Phone Number/Email	
		-) Date of Death (If applicable)	Phone Number/Email	
FAMILY MEMBER #2 INFORMATI Name (Last, First, MI)	N	Date of Birth (MM/DD/YY			Ulissasis // stiss
FAMILY MEMBER #2 INFORMATI Name (Last, First, MI) Biological Sex: F M Ethnicity: Asia		Date of Birth (MM/DD/YY	can American 🗌 White	French Canadian/Cajun	Hispanic/Latino
FAMILY MEMBER #2 INFORMATI Name (Last, First, MI) Biological Sex: F M Ethnicity: Asia	DN an □Ashkenazi Jewish □Jewish n □Middle Eastern □Native Ar	Date of Birth (MM/DD/YY	can American 🗌 White	French Canadian/Cajun	Hispanic/Latino
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ILD-10 code(s): Will medical management change depending upon the results of the test? PROBAND'S PRIMARY INDICATION FOR TESTING Please describe in a few words the main reason for ordering exome testing (Please also provide clinic notes and pedigree): PROBAND'S CLINICAL OVERVIEW (Check all that apply) Audiologic//Otolaryngologic Hematologic Cardiovascular Hematologic Dential Metabolic/Biochemical Renal Dential Movement Disorder Tone abnormalities Dential Metabolic/Biochemical Renal Dential Metabolic/Biochemical Renal Demtalogic Heurologic Heurologic Cardiovascular Hougenotics Hypertonia Demtalogic Renal Hougenotics Demtalogic Renal Hougenotics Demtalogic Renal Hougenotics Gastrointestinal Developmental Delay/Intellectual disability Hypertonia Grewth Disorders: Psychiatric Psychiatric Gordiovarias Autorias (describe): Concologic Abiormal brain MRI Onecologic Congenital Anomalies (describe): Congenisis MRI Ov	INDICATION(S) FOR TESTING				
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Chromosome analysis: Microarray analysis: Other molecular studies:	MRI/CI studies (findings):				
Other molecular studies:					
Differential diagnosis/Genes of interest:					
FAMILY HISTORY (Please attach pedigree)					
Is anyone in the family affected with a similar phenotype as the proband? NO YES, please list exact relationship to proband, symptoms and age of onset of symptoms:					
Is there any consanguinity (conception between blood relatives) in the family? 🗌 NO 📋 YES If yes please describe:					



Clinical Genomics Test Requisition Form - Page 4 of 5

Please check the box next to the test(s) being ordered below. If this TRF is sent to Ambry without or ahead of the sample, it will be treated as a preverification. If test ordered is different than the test preverified, we will honor what is on the TRF order form with the sample. Preverification will only be performed for ExomeNext or SNP Array testing.

For multiple test orders, testing will be run concurrently (multiple tests initiated at the same time) unless otherwise specified. To order reflexive testing (second test starts pending first test outcome), please clearly indicate the order of reflexive tests in the notes section or next to the test check box. For reflex test orders, any positive findings (pathogenic/likely pathogenic) in the first test will be reported out to the clinician, and the requested second test will be canceled; all other findings will automatically reflex (including VUS).

Check to order	Test Name	Test Code	Description	SINGLE SITE ANALYSIS (Please include a copy of relative's report)
Chromosomal Microarray Analysis			Gene(s): Mutation(s):	
	SNP Array ^{^^}	5490	Chromosomal microarray (>2.6 million copy number probes and 750,000 SNP probes)	Relative Name:
	Familial targeted microarray^^	5495	Paid option. Only available following SNP Array (5490) completed at Ambry. Incidental findings unrelated to the variant(s) detected in the proband, will NOT be reported. Name of proband tested at Ambry:	Positive control sample: will be provided already at Ambry not available FOR PRENATAL SPECIMENS, POC OR CORD BLOOD: MATERNAL CELL CONTAMINATION ANALYSIS REQUIRED Both test codes required for fetal specimens. 1260 MCC for amniotic fluid culture or CVS 1262 MCC Reference for maternal blood sample (No Charge)
Exome Se	quencing			OTHER ORDER
	ExomeNext®-Proband	9993	Proband only exome sequencing Secondary Findings [†] :	Please visit ambrygen.com/tests for details. Test Code:Test Name:
	ExomeNext®-Proband plus mtDNA	9994	Proband only exome sequencing plus mtDNA sequencing Secondary Findings [†] : Opt-out	Notes:
	ExomeNext®-Duo	9991	Duo exome sequencing Secondary Findings [†] : ☐ Opt-out	
	ExomeNext®- <i>Duo</i> plus mtDNA	9992	Duo exome sequencing plus mtDNA sequencing Secondary Findings [†] : ☐ Opt-out	
	ExomeNext®- <i>Trio</i>	9995	Trio exome sequencing Secondary Findings†: ☐ Opt-out	
	ExomeNext®- <i>Trio</i> plus mtDNA	9996	Trio exome sequencing plus mtDNA sequencing Secondary Findings [†] :□Opt-out	
	ExomeNext-Rapid® (Institutional billing or patient payment only)	9999R	Rapid Trio exome sequencing plus mtDNA sequencing	
Order	patient payment only)		Secondary Findings [†] : Opt-out	ORDERING CHECKLIST (Required [†])
through Ambry- Port®	ExomeNext®-Select	9500	Up to 500 gene custom exome sequencing test	 Proband specimen Clinical Genomics TRF with patient & clinician signatures
[^] Buccal swab accepted for SNP Array [†] Secondary Findings: If box is left unchecked, the ACMG recommended list of Secondary Findings will be reported. Secondary Findings are not available for ExomeNext-Select orders.				 Clinical history (attach clinic notes) Medical Necessity Form (insurance orders only) (see page 5) Copy of Insurance Card (insurance orders only)
				Orders with missing requirements will be placed on hold until all requirements are received.
				ORDERING CHECKLIST (Highly Recommended)
				Family member specimens Please send all first degree and other informative relatives within 4 weeks of the order.
				Family history or pedigree Family history or pedigree
				Previous test results

CONTACT INFORMATION

For ExomeNext preverification requests please send the Medical Necessity Form and Clinical Genomics TRF to preverification@ambrygen.com or fax to 949-900-5501.

All other documents can be secure uploaded at ambrygen.com/secure-upload, or faxed to 949-900-5501.

AmbryPort is a secure client portal that allows order submission, test status updates, insurance authorization status and report downloads. All required documents can be completed and directly uploaded through AmbryPort during the ordering process or after order submission. Please visit portal.ambrygen.com/signup to sign up.



ExomeNext Medical Necessity Form - Page 5 of 5

REQUIRED FOR INSURANCE ORDERS ONLY (NOT REQUIRED FOR CIGNA MEMBERS)

This form is required if you are ordering Exome testing and wish to have the patient's insurance billed. Please complete and submit with the TRF and a copy of clinical notes. This form replaces the Letter of Medical Necessity.

1. Has the patient had previous Whole Exome Sequencing (WES) performed?

Yes, date performed:	

🗆 No

2. Does this patient have a clinical presentation consistent with the following (select all that apply):

□ Multiple abnormalities affecting unrelated organ systems (please specify): ____

OR two of the following:

□ Abnormality affecting a single organ system(specify): ____

Significant intellectual disability, symptoms of a complex neurodevelopmental disorder (i.e. self-injurious behavior, reverse sleep-wake cycle, or seizure/epilepsy), or severe neuropsychiatric condition (e.g. schizophrenia, bipolar, Tourette syndrome)

□ Family history strongly implicating a genetic etiology (please specify findings and relationships): _

□ Period of unexplained developmental regression (unrelated to autism or epilepsy)

3. Are the results of this WES test expected to directly influence this patient's medical management recommendations and clinical outcome?

☐ Yes (please describe): ____

🗌 No

4. Please describe the genetic tests that would be indicated if WES were NOT performed (i.e., single gene tests, gene panels, etc.):

Chromosomal microarray	
□ Single gene test(s):	
Multigene panel(s):	
Other genetic test(s):	

5. Please describe follow-up procedures & frequency that would be needed if WES were NOT performed (i.e., lumbar puncture, imaging studies, brain MRI, etc.):

□ Imaging study:	ly:	
Surgery:		
□ Biopsy:		
□ Other:		