

Client Information

Required Information

Account #: _____ **Account Name:** _____
Street Address: _____

City, ST, ZIP: _____
Phone: _____ **Fax:** _____

Requisition Completed by: _____ Date: _____
Ordering Physician (please print: Last, First): _____ **NPI #:** _____
Treating Physician (please print: Last, First): _____ **NPI #:** _____
The undersigned certifies that he/she is licensed to order the test(s) listed below and that such test(s) are medically necessary for the care/treatment of this patient.
Authorized Signature: _____ **Date:** _____

Patient Information

Last Name: _____ **Male** **Female**
First Name: _____ **M.I.** _____ **Other Pt ID/Acct #:** _____
Date of Birth: mm _____ / dd _____ / yyyy _____ **Medical Record #:** _____
Client represents it has obtained informed consent from patient to perform the services described herein.

Specimen Information

Specimen ID: _____ **Block ID:** _____
 Fixative/Preservative: _____
Collection Date: mm _____ / dd _____ / yyyy _____ **Collection Time:** _____ AM PM
Retrieved Date: mm _____ / dd _____ / yyyy _____
Hospital Discharge Date: mm _____ / dd _____ / yyyy _____
Body Site: _____
 Primary Metastasis – If Metastasis, list Primary: _____

Bone Marrow [must provide CBC]:
 Green Top(s) _____ Purple Top(s) _____ Core Biopsy _____ Clot _____
 Peripheral Blood: Green Top(s) _____ Purple Top(s) _____ Other _____
 Smears: Air Dried _____ Fixed _____ Stained (**type of stain**) _____
 Slides # _____ Unstained _____ Stained _____ H&E _____
 Paraffin Block(s) #: _____ **Choose best block** (global testing only)
 Blocks will be combined for molecular testing when necessary.
 Perform tests on all blocks

Billing Information

Required: Please include face sheet and front/back of patient's insurance card.

Specimen Origin (Must Choose 1):

- Non-Hospital Patient
 - Hospital Patient (in)
 - Hospital Patient (out)
- See back for definitions.

Bill to:

- Insurance Patient/Self-Pay
- Medicare Medicaid Client Bill
- OP Molecular to MCR, all other testing to Client
- Bill charges to other Hospital/Facility:

Prior Authorization # _____ See the NeoGenomics.com Billing section for more info.

Clinical Information

Required: Please attach patient's pathology report (required), clinical history, and other applicable report(s).

ICD 10 (Diagnosis) Code/Narrative (Required): _____

Reason for Referral: _____

- New Diagnosis Relapse/Refractory Monitoring MRD

Bone Marrow Transplant

- None Autologous Allogeneic Sex Mismatch

Comments

Required Items

- Patient Demographics Pathology Report
- Copy of Insurance Card Clinical History
- CBC Within Last 30 Days Relevant Treatment History

Consultation

COMPASS™ Comprehensive evaluation including morphology

- Blood and/or Bone Marrow
- Paraffin block for Morphology to follow

Lymphoma Consult

- Lymph Node/Tissue for Lymphoma*
- *Split fresh specimens to RPMI and formalin
- Paraffin block for Morphology to follow

A NeoGenomics pathologist will select medically necessary tests (with any exceptions noted or marked by the client) to provide comprehensive analysis and professional interpretation for the materials submitted.

Please attach CBC for Blood and Bone Marrow (required).

- Do not add NGS Profile without prior approval

Next-Gen Sequencing

- Legacy AML Molecular Profile Legacy Lymphoid Molecular Profile
- Legacy AML Molecular Profile + FLT3 (ITD/TKD) by PCR Legacy Myeloid Molecular Profile
- Legacy CLL Targeted Profile NexCourse® Complete

Molecular Genetics

- ABL1 Kinase Domain JAK2 V617F - Quantitative
- B-Cell Gene Rearrangement KIT (c-KIT)
- BCR-ABL1 Standard p210, p190 MPL Mutation Analysis
- BRAF Mutation Analysis MPN JAK2 V617F with Sequential Reflex to JAK2 Exon 12-13, CALR & MPL
- Calreticulin (CALR) MYD88
- FLT3 Mutation Analysis NPM1 Mutation Analysis
- IgVH Mutation Analysis T-Cell Receptor Gamma
- JAK2 Exon 12-13 T-Cell Clonality Beta
- JAK2 V617F - Qualitative Other _____
- Reflex to JAK2 Exon 12-13, if negative
- Reflex to CALR, if negative
- Reflex to MPL, if negative

Flow Cytometry Please attach CBC with all flow requests on blood (required).

Diagnostic/Prognostic Panels

- Standard L/L Panel (24 Markers)
- Extended L/L Panel (31 Markers)
- CD52 Analysis
- High Sensitivity PNH

MRD Panels

- B-ALL MRD
- CLL MRD
- Myeloma MRD

Cytogenetics

- Oncology Chromosome Analysis
- Reflex to FISH if cytogenetics is normal (reflex FISH panel must be selected)
- Reflex to FISH if cytogenetics is incomplete (<20 metaphases)
 - MDS Standard FISH
 - MDS Extended FISH
- Other: _____

FISH

- Anaplastic Large Cell Lymphoma (ALCL)
- ALL - Adult High-Grade B-Cell Lymphoma Reflex
- ALL - Pediatric Low-Grade/Small B-Cell Lymphoma
- B-ALL, Ph-Like MDS Extended
- AML Standard MDS Standard
- AML Non-Favorable Risk MPN
- BCR/ABL1/ASS1 t(9;22) NHL
- CLL Plasma Cell Myeloma
- Eosinophilia Do not reflex to IgH Complex
- High-Grade/Large B-Cell Lymphoma w/BCL6 (3q27), MYC (8q24), BCL2 (18q21) Plasma Cell Myeloma IgH Complex
- Add MYC/IgH/CEN8 t(8;14) Plasma Cell Myeloma Prognostic Panel
- Other _____ Other _____
- Other _____

Plasma Cell Enrichment will be performed on all bone marrow and blood samples having plasma cell FISH tests.

Morphology

- Blood and/or Bone Marrow

Specimen Requirements

Refrigerate specimen if not shipping immediately and use cool pack during transport. Please call Client Services Team with any questions regarding specimen requirements or shipping instructions at 866.776.5907 option 3. Please refer to the website for specific details on each specimen.

Additional Billing Information

Any organization referring specimens for testing services pursuant to this Requisition Form ("Client") expressly agrees to the following terms and conditions.

- 1. Binding Service Order.** This Requisition Form is a legally binding order for the services ordered hereunder ("Services") and Client agrees that it is financially responsible for all tests billable to Client hereunder.
- 2. Third Party Billing by NeoGenomics and Right to Bill Client.** Client agrees to accurately indicate on the front of the Requisition Form that either Client should be billed (e.g., Client receives reimbursement pursuant to a non-fee-for-service basis, including, but not limited to, a capitated, diagnostic related group ("DRG"), per diem, all-inclusive, or other such bundled or consolidated billing arrangement) or NeoGenomics should bill the applicable federal, state or commercial health insurer or other third party payer (collectively, "Payers") for all Services ordered pursuant to this Requisition Form. For all such Services billable to Payers, Client agrees to provide all billing information necessary for NeoGenomics to bill such payer. In the event NeoGenomics: (i) does not receive the billing information required for it to bill any Payers within ten days of the date that any Services are reported by NeoGenomics; (ii) the Services were performed for patients who have no Payer coverage arrangements; or (iii) the Payer identified by Client denies financial responsibility for the Services and indicates that Client is financially responsible, NeoGenomics shall have the right to bill such Services to Client.

Definitions of Patient Status for Specimen Origin

Non-Hospital Patient: Patient is not registered at a hospital (neither an in-patient nor out-patient)

Hospital Patient (in): Patient is registered and admitted to a hospital overnight

Hospital Patient (out): Patient is registered and admitted to a hospital, then discharged before the end of the day

Test Descriptions

Please see complete test descriptions and all available tests at our website, www.neogenomics.com.

Test Notations

Specimen Usage

NeoGenomics makes every effort to preserve and not exhaust tissue, but in small and thin specimens, there is a possibility of exhausting the specimen in order to ensure adequate material and reliable results.

FISH

Plasma cell myeloma FISH panels: Plasma cell enrichment will be performed on bone marrow and blood samples having plasma cell FISH. Sample should be received at NeoGenomics Laboratories within 72 hours of collection.