

Client Information

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

 City, ST, ZIP: _____
 Phone: _____ Fax: _____
 Additional Reporting 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: _____

Billing Information

Patient Status (Must Choose 1): Bill to: Medicare Insurance Patient/Self-Pay
 Hospital Patient (in) Client
 Hospital Patient (out)
 Non-Hospital Patient
 RaDaR Assay ABN/Non-Covered Testing Form required with patient signature. Attached: Yes No
 Please include face sheet and front/back of patient's primary and secondary insurance cards.
 Please see NeoGenomics.com for more information or contact Billing at 866.776.5907 x2.
 Prior Authorization # if required _____ See NeoGenomics.com Billing section for more info.

Select Testing

Tissue and/or initial blood specimen:
 RaDaR First-Time Set-Up, 1 blood test
 RaDaR First-Time Set-Up, 4 sequential blood tests
 Returning patients (blood only):
 RaDaR Subsequent Test, 1 blood test
 RaDaR Subsequent Test, 4 sequential blood tests

Select Blood Collection Plan

NeoGenomics managed mobile phlebotomy
Client to specify intervals of up to 4 draws:
 Monthly Every ___ weeks Every ___ months
 By completing this section, Client represents it has obtained patient's consent to be contacted by third-party service.
 Clinic-managed blood draws (client will submit blood; new order required after maximum 4 draws)
 Send reminder notices to:
 Contact Name: _____
 Email, Phone, or Fax: _____
 Monthly Every ___ weeks Every ___ months
 Call me to discuss draw schedule
 Name: _____
 Phone number: _____

Patient Information

Last Name: _____ Male Female
 First Name: _____ M.I. _____ Other PtID/Acct#: _____
 Date of Birth: mm ____ / dd ____ / yyyy ____ Medical Record #: _____
 Home Address: _____
 City, ST, ZIP: _____
 Phone (mobile preferred): _____
 Email: _____
 By completing this section, Client represents it has obtained informed consent from patient to perform the services described herein.

Clinical Information

Pathology report attached (required with tumor submission)
 Most recent clinical history attached
 ICD 10 (Diagnosis) Code/Narrative (required): _____
 Tumor Type: Colorectal Lung Breast Head & Neck
 Other (specify): _____
 For Other, provide rationale for testing: _____
 Other tumor types require NeoGenomics medical director approval. We recommend calling in advance to review Other cases.
 Status: Active Disease/Adjuvant Surveillance Stage at Dx: I II III IIIA IIIB IV
 Date of resection or curative intent therapy: mm ____ / dd ____ / yyyy ____

Blood Specimen Information

Specimen ID: _____
 Collection Date: mm ____ / dd ____ / yyyy ____ Collection Time: _____ AM PM
 Peripheral Blood: Streck Cell-Free DNA BCT# _____

Tissue Specimen Information

PATHOLOGY TO COMPLETE

Specimen ID: _____ Block ID: _____
 Fixative/Preservative: _____ Retrieved Date: mm ____ / dd ____ / yyyy ____
 Collection Date: mm ____ / dd ____ / yyyy ____ Collection Time: _____ AM PM
 Hospital Discharge Date: mm ____ / dd ____ / yyyy ____
 Slides # _____ Unstained _____ Stained _____ H&E _____
 Primary Metastasis
 Paraffin Block(s) #: _____ Submit ≤4 blocks. Blocks will be combined when necessary.

3rd Party Specimen Location

ONCOLOGY OFFICE TO COMPLETE & FAX

Client will arrange shipment of tissue. Include a copy of this requisition with the tissue to prevent duplicate orders. **OR**
 Complete the following for NeoGenomics to obtain tissue from Pathology site. **Please fax** this completed requisition and pathology report to **239.690.4237**.
 Location of Specimen: _____
 Street Address: _____
 City: _____ ST: _____ ZIP: _____
 Phone: _____ Fax: _____
 Body Site: _____
 Collection Date: mm ____ / dd ____ / yyyy ____ Collection Time: _____ AM PM

Specimen Requirements

Please call NeoGenomics' Patient Advocate Team with any questions regarding specimen requirements or shipping instructions at 866.776.5907 option 9. Please refer to the website for specific details on each specimen.

RaDaR® tumor types: The RaDaR assay has been validated under CLIA/CAP conditions for the detection of ctDNA in patients with breast, colorectal, lung, and head & neck tumors

RaDaR blood specimens: Do not refrigerate or freeze. Special collection tubes and shipping requirements apply. Please contact Patient Advocate Team for kit and see instructions provided in kit.

RaDaR tumor tissue specimens: Paraffin block preferred over cut slides. Please see website and contact Patient Advocate Team for RaDaR Tissue Transport kit if needed.

Test Notes

RaDaR Residual Disease and Recurrence

RaDaR is a laboratory developed test performed by Inivata, Inc., a subsidiary of NeoGenomics. See finditwithRaDaR.com for test details.

Contraindications

The RaDaR assay is not available to patients who are pregnant, have concurrent malignancies, have had blood transfusions within three months prior to blood sample, or have had allogeneic bone marrow/stem cell transplant at any time.

Tissue 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.

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 contractually 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.



Blood Draw Intervals




To direct NeoGenomics to collect blood at client-defined intervals, choose NeoGenomics managed mobile phlebotomy on reverse and provide intervals for up to four draws. The first blood draw must be at least two weeks after resection or curative intent therapy.

For discussion of your case to set draw intervals, NeoGenomics Medical Science Team members are happy to contact you about options for patients with breast, colorectal, lung, and head & neck tumors. Choose the "Call me" option on reverse.

Blood draw interval examples: below are suggested schedules for adjuvant and surveillance phases.

Adjuvant Phase Example				
WEEKS AFTER RESECTION or other treatment with curative intent				
W0 RESECTION	W4 +/-1w	W8 +/-2w	W12 +/-2w	W16 +/-2w
				
Tissue	Blood Sample 1 Baseline	Blood Sample 2	Blood Sample 3	Blood Sample 4

6 MONTHS+	
6M - 24M every 3m ± 2w	> 24M every 6m ± 2w
	
Blood Sample every 3M	Blood Sample every 6M up to 5 years

Surveillance Example		
MONTHS AFTER RESECTION or other treatment with curative intent		24 MONTHS +
M0 RESECTION	M3 - M24 every 3m ± 2w	>24M every 6m ± 2w
		
Tissue	Blood Sample every 3M	Blood Sample every 6M up to 5 years

Optional Patient signature

I am interested in participating in research studies conducted by NeoGenomics. By checking this box, and signing my name, I consent to be contacted by NeoGenomics about participation in future research studies. I understand that checking this box and signing my name does not obligate me to participate. My signature here is not required to initiate RaDaR testing.

Patient/Guardian signature: _____ Date: _____

For our complete test menu, TATs, specimen requirements and more, please visit: www.neogenomics.com