# Caris ChromoSeq™ Heme Test Request Form

For Project ID Use Only

**Phone: (888) 979-8669 | Fax: (866) 479-4925 | Email: CustomerSupport@CarisLS.com**

Please complete and return by fax or email. Incomplete or missing information may result in delayed testing.

## TREATING PHYSICIAN INFORMATION *Section required.*

| | | |
|---|---|---|
| Name | | NPI |
| Physician Email | Office Contact Name | |
| Office/Hospital Name | Address | |
| City | State | Zip |
| Phone | Fax | |

## PATIENT INFORMATION *Section required.*

| | | | |
|---|---|---|---|
| Last Name | First Name | | MI |
| In-Office Medical Record Number | DOB | Biological Sex ☐M ☐F | Ethnicity |
| Address | | | Apt. |
| City | | State | Zip |
| Mobile Phone | Email | | |

## TEST DESCRIPTION

☐ **Caris ChromoSeq**

Caris ChromoSeq – a whole genome (WGS) sequencing assay to detect clinically relevant single-nucleotide variants (SNVs), insertions/deletions (INDELs), copy number alterations (CNA), and structural variants (SVs/Fusions) in hematological neoplasms. These capabilities are accomplished by the extraction of DNA from patient bone marrow or whole blood collections before performing deep sequencing on each sample to identify actionable genetic alterations in the DNA in patients with newly diagnosed or recurrent hematologic malignancies.

PLACE PATIENT ID/SPECIMEN LABEL HERE

## SPECIAL INSTRUCTIONS/ADDITIONAL CC PHYSICIAN CONTACT INFORMATION (OPTIONAL)

| | | |
|---|---|---|
| Special Instructions | | |
| Additional Physician Name to be Copied | Facility Name | Additional Physician Email |

## PATHOLOGY INFORMATION *Section required.*

| | | | |
|---|---|---|---|
| Pathology Services/Specimen Storage Location | Address/Suite | | City |
| State | Zip | Phone | Fax |

## BILLING INFORMATION *Attach the front and back of PRIMARY and SECONDARY insurance cards. Patient insurance/payment is REQUIRED to begin testing.*

☐ Insurance ☐ Self Pay

☐ Direct/Client Bill # _____

☐ HMO/Referral # _____

☐ Other _____

| | Insurance Provider | Policy # | Group # | Insured Name | Insured DOB | Relationship to Patient | Prior Authorization # |
|---|---|---|---|---|---|---|---|
| Primary | | | | | | | |
| Secondary | | | | | | | |

## CLINICAL/SPECIMEN INFORMATION *Selection required. Include a copy of the most recent CBC result and the preliminary bone marrow report for IPSS-M and IPSS-R risk stratification when applicable.*

ICD-10 Code(s)

Specimen Type
☐ Bone Marrow Aspirate ☐ Whole Blood

☐ Hospital Inpatient
☐ Hospital Outpatient
☐ Office/Non-Hospital
☐ Not yet discharged *OR*
☐ Discharge date: _____

Specimen Collection Date and Time (MM/DD/YYYY)

Facility Where Procedure Performed/Collected

Patient has a suspected diagnosis of
☐ Myelodysplastic Syndromes (MDS) ☐ Myeloproliferative Neoplasms (MPN) ☐ Acute Myeloid Leukemia (AML)

## PHYSICIAN ATTESTATION OF MEDICAL NECESSITY *Signature required.*

This requisition constitutes an order for molecular testing from Caris MPI, Inc. (Caris) I certify (a) the services are medically necessary and will assist me in treating my patient, (b) the patient has sufficient performance status to receive additional treatment, (c) I will make available patient medical records documenting the foregoing, and (d) I supplied information to the patient regarding this testing, explained the purpose of this testing to the patient, and obtained informed consent for (i) such testing, (ii) any analysis and reports related to such testing, (iii) Caris to retain testing results, samples and related information and analysis, (iv) Caris' use or disclosure (including to third parties) of deidentified information generated from such testing for general research and other purposes, (v) Caris' disclosure of testing results and information to third-party payers in connection with such testing, and (vi) for Caris to contact the patient regarding the testing.

**Authorized Provider Signature** ☐ *I have conferred with the treating provider and am ordering per his/her request for use in determining treatment options for their patient.*

**Provider Name (Print)**

**Date**