otogenetics® corporation

Genetic Test Requisition Gx™

Please submit both pages of this form.

LABORATORY USE ONLY:	DATE RECEIVED:	ACCESSION NO:	SPECIMEN ID:

1. PATIENT INFORMATION (REQUIRED)

First Name____________________ Last Name_______________________

DOB(mm/dd/yyyy) _________________ ☐ Male ☐ Female Age_____

Address____

City_____________________ State________ Zip Code ______________

Phone ____________________ Email______________________________

2. ORDERING PHYSICIAN INFORMATION (REQUIRED)

First Name_______________ Last Name_________________________

Medical Credentials________ NPI#__________________________

Facility Name____

Address____

City_________________________ State________ Zip______________

Direct Office Contact (Required) ____________________________

Phone____

3. ADDITIONAL RESULTS RECIPIENT

Healthcare Professional Name ________________________________

Phone______________________ Fax____________________________

Email (for notification of results only)_______________________

Mailing Address____

City__________________________ State_______ Zip_______________

4. SPECIMEN INFORMATION (REQUIRED)

Date of Collection______________ Collected By________________

Specimen Type ☐ Saliva ☐ Blood (Lavender Top)

5. TEST(S) REQUESTED

Hereditary Cancers

- ☐ **BRCA1/2 – 2 genes.** Sequencing and duplication/deletion analysis
- ☐ **Breast and Ovarian Cancer – 15 genes** ATM, BRCA1, BRCA2, BRIP1, CDH1, MLH1, MSH2, MSH6, PALB2, PTEN, RAD51C, RET, STK11, TP53, VHL
- ☐ **Inherited Cancer Panel – 39 genes** linked to breast, ovarian, colon, pancreatic, and other major cancers
- ☐ **Colorectal Cancer Panel - 12 genes** APC, BMPR1A, CDH1, EPCAM, MLH1, MSH2 MSH6, MUTYH, PMS2, PTEN, SMAD4, STK11
- ☐ **Lynch Syndrome - 5 genes.** Sequencing and duplication/deletion analysis. EPCAM, MLH1, MSH2, MSH6, PMS2

Pharmacogenomics

- ☐ **PGx Panel/Pain Management/ Mental Health/ Infectious Diseases**
- ☐ **PGx Panel/Pain Management/ Women's Health**
- ☐ **PGx Panel/Oncology/Surgical/Thrombosis Risk/Cardiovascular**

Carrier Screening

- ☐ **CF**
- ☐ **CF, SMA, Fragile X – 6 genes**
- ☐ **ACOG/ACMG – 12 genes**
- ☐ **Pan-ethnic - 107 genes**

- ☐ **Deafness Panel – 130 genes**
- ☐ **Cardiomyopathy – 44 genes**
- ☐ **Usher Syndrome – 10 genes**
- ☐ **Custom Gene or Panel**

6. ICD10 CODES (REQUIRED)____

7. MEDICAL NECESSITY / CHART NOTES: Please complete the reverse side of this form and attach clinical notes for medical necessity

8. PATIENT INFORMED CONSENT (Please sign here or the consent form)

- ☐ I have read the Informed Consent Form and give permission to Otogenetics to perform the genetic tests as described.
- ☐ **Optional**: I consent to use of my de-identified test samples for research.
- ☐ **Optional**: I consent to be contacted by Otogenetics for research opportunities.
- ☐ **Optional**: I am a New York State resident and I consent to storing my test samples at Otogenetics beyond 60 days for future use or testing

Patient Signature: ______________________________Date:_________________

9. CONFIRMATION OF INFORMED CONSENT AND MEDICAL NECESSITY

The tests ordered are medically necessary for the risk assessment, diagnosis or detection of a disease, illness, impairment, symptom, syndrome or disorder. The results will determine the patient's medical management and treatment decision. The person listed as the Ordering Physician is legally authorized to order the test(s) requested herein. The patient was provided with information about genetic testing and has consented to genetic testing.

Ordering Physician Signature:__________________________Date:___________

10. PATIENT PAYMENT OPTIONS

- ☐ **INSURANCE:** Please attach a copy of front and back of insurance card
- ☐ **INVOICE PRACTICE / INSTITUITIONAL BILL / FACILITY BILL**
- ☐ **CREDIT CARD** Otogenetics will contact you for additional information

I am covered by insurance and understand and authorize:

- Otogenetics to give my health insurance plan information on this form and other information provided by my healthcare provider that is necessary for reimbursement.
- Otogenetics to inform my plan of my test result only if required for preauthorization or payment of additional or reflex testing.
- Plan benefits to be payable to Otogenetics.
- Otogenetics to attempt to contact me about my out of pocket responsibility.
- I am responsible for sending Otogenetics all of the money I receive directly from my health plan for this test.

Patient Signature: __________________________Date:___________

otogenetics corporation

Genetic Test Requisition Gx™

Please submit both pages of this form.

11. ANCESTRY (Select all that apply)

☐ White / Non-Hispanic	☐ Ashkenazi Jewish	☐ Pacific Islander
☐ Hispanic / Latino	☐ Asian	☐ Middle Eastern
☐ Black / African	☐ Native American	☐ Other

12. PATIENT PERSONAL HISTORY OF CANCER & OTHER CLINICAL INFORMATION

☐ Patient has NO personal history of cancer

Patient has been diagnosed with:	Age at Diagnosis	Patient is Currently Being Treated	Pathology and Other Information
☐ Breast Cancer ☐ Left ☐ Right		☐	☐Ductal Invasive ☐ Lobular Invasive ☐DCIS ☐Bilateral ☐Premenopausal ☐ Triple Negative (ER-, PR-, HER2-)
☐ Endometrial/Uterine Cancer		☐	☐Tumor MSI-HIGH or IHC Abnormal Result ____________________
☐ Ovarian Cancer		☐	☐Non-epithelial
☐ Prostate Cancer		☐	Gleason Score__________
☐ Colon/Rectal Cancer		☐	Type: ☐Mucinous ☐Signet Ring ☐ Medullary Growth Pattern ☐Tumor Infiltrating Lymphocytes ☐Crohn's-like Lymphocytic Reaction ☐Patient's tumor is MSI-HIGH or Abnormal Result______________
☐ Colon/Rectal Adenomas		☐	Cumulative Adenomatous Polyp # ☐1 ☐2-5 ☐6-9 ☐10-19 ☐20-99 ☐100+
☐ Hematological Cancer		☐	
☐ Other Cancer		☐	
Check if applicable to patient:	☐ Bone marrow transplant recipient		

13. FAMILY HISTORY OF CANCER

☐ No Known Family History of Cancer ☐ Limited Family Structure

Relationship to Patient	Maternal	Paternal	Cancer Site or Polyp Site	Age at Each Diagnosis
Mother	☐	☐		
Aunt	☐	☐		
	☐	☐		
	☐	☐		

14. BREAST CANCER RISK INFORMATION (Only Complete for patients NEVER diagnosed with breast cancer)

Height____ Weight_____
Age at first menstrual period_______
Is Patient: ☐Pre-menopausal ☐ Peri-menopausal
☐Post-menopausal: Age of onset_____
Has this patient has a live birth? ☐No ☐Yes
Age at time of first child's birth____

Has patient ever used Hormone Replacement Therapy? ☐No ☐Yes
If Yes, Treatment Type:
☐ Combined ☐Estrogen Only ☐Progesterone Only
If Yes, is patient a: ☐ Current User: Started_____ yrs ago
Plans to use for ____yrs ☐ Past User: Stopped _______yrs ago

If patient had a breast biopsy, were the results: ☐No Benign Disease
☐Hyperplasia ☐Atypical Hyperplasia ☐LCIS ☐Unknown

Patient's Female Relatives

Number of Daughters______
Number of Sisters_________
Number of Maternal Aunts__
Number of Paternal Aunts__

15. FOR PHARMACOGENETICS TEST PANELS ONLY

For complete pharmaceutical drug & corresponding gene list – please see attached list

Women's Health
- ☐ Flibanserin (ADDYI)
- ☐ Drospirenone and Ethinyl Estradiol (Gianvi, Loryna, Nikki Ocella, Syeda, Vestura Yasmin, YAZ, Yaz 28 Zarah)
- ☐ Other____________ __________________

Oncology
- ☐ Antidepressants
- ☐ Chemotherapeutics
- ☐ Corticosteriods
- ☐ Immunosuppressants
- ☐ NSAIDs
- ☐ Opiods

Pain Management
- ☐ Antidepressants
- ☐ Antiepileptics
- ☐ Benzodiazepines
- ☐ General Anesthetics
- ☐ Muscle Relaxants
- ☐ NSAIDs
- ☐ Opiods

Mental Health
- ☐ ADHDs
- ☐ Antidepressants
- ☐ Antiepilectics
- ☐ Antipsychotics

Cardiology
- ☐ Antiarrhythmics
- ☐ Anticoagulants
- ☐ Antidiabetics
- ☐ Antihypersensitives
- ☐ Platelet Aggregation Inhibitors
- ☐ Statins
- ☐ Thrombophilia

Other
- ☐ CFTR
- ☐ Hepatitis, antivirals
- ☐ HIV/AIDS
- ☐ Immuno-suppressants
- ☐ Proton Pump Inhibitors
- ☐ Other _______ ______________