ThyGeNEXT® THYROID ONCOGENE PANEL / ThyraMIR®v2 THYROID miRNA RISK CLASSIFIER

Interpace Diagnostics
2515 Liberty Avenue
Pittsburgh, PA 15222

MOLECULAR

Phone: 844-405-9655 • Email: labsupport@interpace.com • Fax: 888-674-6894 • interpace.com

1. Patient Information

Please print or adhere patient label. Must include 2 unique identifiers.

Last Name

First Name

Date of Birth (mm/dd/yy) | SSN/MRN

Biological Sex: ☐ Male ☐ Female

2. Physician Information

Submitting Physician	Referring/Treating Physician
Account #:	Account #:
Office/Hospital:	Office/Hospital:
Address:	Address:
Phone:	Phone:
Fax:	Fax:
Office Contact:	Office Contact:
Email:	Email:
	Contact Preference: ☐ No Contact ☐ CC Test Results
Institution NPI:	Institution NPI:
Physician NPI:	Physician NPI:

3. Billing Information

Procedure Location

☐ Outpatient ☐ Non-Hospital Affiliated Setting

☐ Private Practice ☐ Inpatient/Discharge Date: ____/____/____

ICD Code(s)

Codes for your consideration (please do not circle, see reverse side for more information)

E04.2 Nontoxic, multinodular goiter thyroid gland
E04.1 Nontoxic, single thyroid nodule
D44.0 Neoplasm of uncertain behavior of thyroid gland
D34 Benign neoplasm of thyroid

The diagnosis code(s) provided should always be based upon what can be supported within the patient's medical records. Testing cannot be done unless ICD code(s) are included.

4. Specimen & Diagnosis Information

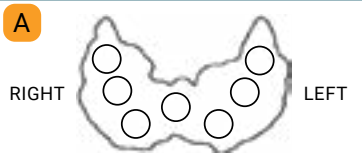
Please indicate type and number submitted.

FNA in Collection Buffer Vial(s) | # Cytology Slide(s)

Submitted Collection Date

For multiple nodules, indicate the locations on the diagram and correlate with labels attached below.

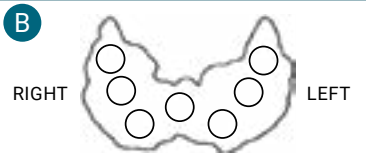
A



Location _____

Size _____

B



Location _____

Size _____

Cytology Diagnosis (Bethesda Category)

A	B		A	B	
☐	☐	Atypia of undetermined significance (B-III)	☐	☐	Nondiagnostic (B-I)*
☐	☐	Follicular neoplasm (B-IV)	☐	☐	Benign (B-II)*
☐	☐	Suspicious for malignancy (B-V)	☐	☐	Malignant (B-VI)*

Please attach a copy of the Cytology and Ultrasound Reports

**Requires Letter of Medical Necessity (LOMN)*

Clinical History/Comments

5. Method of Payment Information

A copy of the patient's billing and demographics information is required for testing. Failure to supply this information will delay results.

☐ Medicare ☐ Medicaid ☐ Private Insurance
☐ Self Pay ☐ Ordering Institution

Interpace Diagnostics will bill directly for insured patients, wherever permitted by government regulations, payer billing policies, or contractual arrangements. If patient or insurance information is not completed or attached, your facility will be billed.

6. Test Menu and Authorization

☐ **ThyGeNEXT® w/Reflex to ThyraMIR®v2**

ThyGeNEXT w/Reflex to ThyraMIRv2 better discriminates benign from malignant nodules providing further risk assessment. *BRAF* V600E-like mutations that are highly predictive of malignancy are included in ThyGeNEXT. *RAS*-like mutations, which are less predictive of malignancy, are also included in ThyGeNEXT. If ThyGeNEXT is negative for mutations or not fully predictive of malignancy, ThyraMIRv2 testing will be performed in reflex.

☐ **ThyGeNEXT® only**

ThyGeNEXT includes the most common mutations associated with all types of thyroid cancer. When identified, *BRAF* V600E-like mutations are highly predictive of malignancy. This selection does not provide the benefit of ThyraMIRv2 for further risk stratification when no mutation or a *RAS*-like mutation is identified.

I hereby certify that the request for the above test for which reimbursement from Medicare or third-party payors will be sought is reasonable and medically necessary for the diagnosis, care, and treatment of this patient's condition. I also authorize providing this patient's test results to the patient's third-party payor. I certify that the treating physician has ordered the above test.

MD/DO Signature | Order Date

Print Name

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Requisition Instructions

Incomplete or incorrect information will lead to testing delays.

Section 1. Patient Information

All fields are required. Include patient first and last name, date of birth, SSN/MRN code, and biological sex. A complete patient label can be adhered in this field as long as patient information is complete and includes 2 unique identifiers. **Incomplete information will result in testing delays.**

Section 2. Physician Information

This section may be pre-filled if an account has been set up with Interpace Diagnostics. If blank, complete each field. Account Number should match your Interpace Diagnostics account number (leave blank if unknown). Complete physician institution contact information. Please avoid Office/Hospital acronyms or abbreviations and spell out the institution name. **Referring/Treating Physician:** Please provide full name and phone/fax number for referring/treating physician, if applicable. Check the box to indicate if you would like the referring/treating physician to receive a copy of the results. **Leaving contact information incomplete will result in processing delays.**

Section 3. Billing Information

Check the box to indicate where procedure was performed (Nonhospital affiliated setting, Private Practice, Outpatient, or Inpatient with discharge date).

Testing cannot be performed unless ICD-10 code(s) are included. Write in the appropriate ICD-10 code based on the patient's medical records. The ICD diagnosis code must be defined by the most detailed level of specificity available. If a diagnosis code cannot be supported by the patient's medical record, then the code should not be used for ordering laboratory services. The list of common ICD diagnosis codes for the characterization of thyroid nodules shown below is not complete. Please refer to the ICD manual for a complete listing.

Common ICD-10 Diagnosis Codes:

D34 - Benign neoplasm of thyroid gland
D44.0 - Neoplasm of uncertain behavior of thyroid gland
D44.9 - Neoplasm of uncertain behavior of unspecified endocrine gland
E01.0 - Iodine-deficiency related diffuse (endemic) goiter
E01.1 - Iodine-deficiency related multinodular (endemic) goiter
E01.2 - Iodine-deficiency related (endemic) goiter, unspecified
E04.0 - Nontoxic diffuse goiter
E04.1 - Nontoxic single thyroid nodule
E04.2 - Nontoxic multinodular goiter
E04.8 - Other, specified nontoxic goiter
E04.9 - Nontoxic goiter, unspecified

Section 4. Specimen & Diagnosis Information

Submitted Specimen(s): Indicate number of vials or slides being sent (REQUIRED). If submitting multiple nodules, indicate type and quantity separately.

Specimen Collection Date: Enter the date of the procedure when specimen was collected. Mark the circle on the thyroid diagram to indicate location of the nodule. The requisition can be used to submit specimens for up to 2 locations. Use letter A for the first specimen and letter B for the second. Provide a descriptive name for each location on the line provided along with the size of each nodule.

Cytology Diagnosis (Bethesda Category): Check the box that corresponds with the patients' medical records to indicate the cytology diagnosis. A copy of the corresponding cytology report is requested to be sent with this specimen, as available. If these reports are not available at time of specimen submission, please forward to Client Services (fax: 1-888-674-6894 or 412-224-6425) when received.

Section 4. (cont.)

Please note that for Nondiagnostic (B-I), Benign (B-II), and Malignant (B-VI) categories, a Letter of Medical Necessity is required to start testing.

Ultrasound Report: Please provide a copy of the patient's ultrasound report and/or relevant supporting documentation.

Please refer to the Directory of Services for full information on accepted specimens types and submission requirements. Visit www.thygenext-thyramir.com/dos.

Section 5. Method of Payment Information

Check the box indicating how the testing should be billed. Interpace Diagnostics will submit claims to all private insurance, Medicare, and other government plans for insured patients.

Patient Contact Information: Please provide a copy of the patient's face sheet or demographics page to include the patient's full name, biological sex, date of birth, address, and phone number.

A copy of the patient's billing information MUST be submitted with specimen.

Medicare/Medicaid/Private Insurance: Provide a clear copy of the front and back of the patient's primary insurance/Medicaid/other payer card. If the patient has a secondary insurance please provide a clear copy of the front and back of the secondary insurance card.

Ordering Institution: Check this box if Interpace Diagnostics is to bill the ordering institution for the ordered testing.

Patient Self-Pay (no insurance): Check this box if the patient has no insurance.

Section 6. Test Menu and Authorization

Specimen processing cannot begin until there is a clear indication of the type of testing to be performed (check box). Please indicate tests requested for patient specimen. Details of each test can be found on our website and in test details from our Directory of Laboratory Services. Only 1 test should be selected (duplicate test selections within a Test Requisition Form cannot be processed and can delay testing).

The ordering physician is required to sign and date the requisition as authorization for Interpace Diagnostics to perform testing. Stamped signatures or physician initials cannot be accepted. An incomplete signature will result in testing delays. Order date cannot precede Collection Date of the specimen. **Post-dated requisitions are not accepted.**

Questions?

Contact Interpace Diagnostics Customer Service at:

Phone: 844-405-9655 or 412-224-6900

Fax: 1-888-674-6894 or 412-224-6425

Email: clientservices@interpace.com

Website: www.interpace.com

Interpace Diagnostics®