ThyGeNEXT® THYROID ONCOGENE PANEL | ThyraMIR® THYROID miRNA CLASSIFIER

Interpace Diagnostics
2515 Liberty Avenue
Pittsburgh, PA 15222

MOLECULAR REQUISITION FORM

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 two (2) unique identifiers.

Last Name: _____ First Name: _____

Date of Birth (mm/dd/yy): ____/____/____

SSN/MRN: Gender: ☐ M ☐ F

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: _____ _____ _____

*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* ***D34.0** 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

Submitted Specimen(s):

____ # 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 _____ B _____

Size: _____ Size: _____

Cytology Diagnosis (Bethesda Category):

A	B		A	B	
☐	☐	Atypical/FLUS (III)	☐	☐	Nondiagnostic (I)+
☐	☐	Suspicious for Neoplasm (IV)	☐	☐	Benign (II)+
☐	☐	Suspicious for Cancer (V)	☐	☐	Malignant (VI)+

+Requires Letter of Medical Necessity (LOMN)

PLEASE ATTACH A COPY OF THE CYTOLOGY REPORT

Ultrasound Characteristics (check all that apply):

A	B		A	B	
☐	☐	Peripheral Vascularity	☐	☐	Rim Calcifications
☐	☐	Intranodular Vascularity	☐	☐	Macrocalcifications
☐	☐	Avascular	☐	☐	Microcalcifications
☐	☐	Hyperechoic	☐	☐	Isoechoic
☐	☐	Hypoechoic			

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 ☐ Ordering Institution ☐ Self Pay

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®**

ThyGeNEXT w/ Reflex to ThyraMIR better discriminates benign from malignant nodules and provides risk assessment. TERT and BRAF V600E and other mutations (BRAF-like mutations) that are highly predictive of malignancy are included in ThyGeNEXT. Also other mutations less predictive of thyroid cancer (RAS-like mutations) are also included in ThyGeNEXT. If mutations in ThyGeNEXT are negative or not fully predictive of malignancy, ThyraMIR testing will be performed in reflex.

☐ ThyGeNEXT only

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 _____

Print Name: _____

Order Date: _____

Specimen A	Specimen A	Specimen B	Specimen B
Patient Name:	Patient Name:	Patient Name:	Patient Name:
DOB:	DOB:	DOB:	DOB:

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****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 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 acronym or abbreviations & 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 indicating how the testing should be billed. Interpace Diagnostics will submit claims to all private insurance, Medicare and other government plan for insured patients.

Private Insurance/Medicare/Medicaid: 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.

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

Submitting Diagnosis: Write in appropriate ICD-10 code based on the patient's medical records. The diagnosis code(s) provided should always be supported by documentation within the patient's medical records. Testing cannot be performed unless ICD-10 code(s) are included. The ICD diagnosis code must be defined by the most detailed level of specificity available and should always be based on what has been documented in the patient's medical record. 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:
D34.0- 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

Specimen & Diagnosis: Check the box to indicate where procedure was performed (Non-hospital affiliated setting, Private Practice, Outpatient, or Inpatient with discharge date).

Submitted Specimen(s): Check the box to indicate type of specimen being sent in for testing OR indicate number of 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 the letter A for the first specimen and letter B for the second specimen. 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. Please note that for Bethesda I, II, and VI categories a Letter of Medical Necessity is required to start testing.

Ultrasound Characteristics: Indicate key characteristics identified from patient's medical records & ultrasound report. Provide relevant clinical history for the patient. Please provide relevant medical records at no cost when requested by the patient's insurance carrier for reimbursement.

Section 5. Test Menu

Specimen processing cannot begin until there is a clear indication of 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.

Section 6. Authorization

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®
Resolving Diagnostic Uncertainty