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@interpacedx.com Fax: 888-674-6894 InterpaceDiagnostics.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: _____ **Sex:** ☐ M ☐ F

② Physician Information

Submitting Physician

Account #: _____

Office/Hospital: _____
Address: _____
Phone: _____
Fax: _____

Email: _____ Office Contact: _____
NPI #: _____
Results Delivery: ☐ Fax ☐ Mail

Referring/Treating Physician

Office/Hospital: _____
Physician Name: _____
Phone: _____ Fax: _____

③ Billing Information

A COPY OF THE PATIENT'S BILLING INFORMATION MUST BE SUBMITTED.

☐ 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.

④ Specimen & Diagnosis Information

Procedure Location:

☐ Non-Hospital Affiliated Setting ☐ Private Practice ☐ Outpatient ☐ Inpatient/Discharge Date: ___/___/___

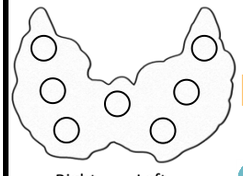
Submitted Specimen(s):

Please indicate type and number submitted

____ # FNA in RNARetain®* Vial(s)

____ # Cytology Slide(s)

Specimen Collection Date: _____/_____/_____



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

A _____ Size: _____

B _____ Size: _____

Cytology Diagnosis (Bethesda Category):

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

+Requires Letter of Medical Necessity (LOMN)

PLEASE ATTACH A COPY OF THE CYTOLOGY REPORT

Ultrasound Characteristics (check all that apply):

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

Clinical History/Comments: _____

Submitting Diagnosis:

ICD Codes: _____ _____
_____ _____

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

Codes for your consideration (please do not circle):
D44.0 Neoplasm of uncertain behavior of thyroid gland
D34 Benign neoplasm of thyroid
E04.1 Nontoxic, single thyroid nodule
E04.2 Nontoxic, multinodular goiter thyroid gland

⑤ Test Menu

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

ThyGeNEXT® w/ Reflex to ThyraMIR® better discriminates benign from malignant nodules and provides risk assessment. TERT and BRAF mutations are included in ThyGeNEXT®. If mutations in ThyGeNEXT® are negative or not fully indicative of malignancy, ThyraMIR® testing will be performed in reflex.

☐ ThyGeNEXT® only

⑥ Authorization

MD/DO Signature _____

Print Name: _____

Order Date: _____

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 certifiy that the treating physician has ordered the above test.

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

*RNARetain® is a registered trademark of Asuragen, Inc