PANCRAGEN™
PANCREATIC CANCER RISK CLASSIFIER

PANCREATIC MOLECULAR REQUISITION for SECOND-LINE TESTING 2

Fax completed requisition to: 888-674-6894 | **Client Services: 800-495-9885 | labsupport@interpacediagnostics.com**

For additional information, please contact Client Services

1. CLINICAL REPORTS REQUEST

☐ EUS ☐ CYTOLOGY ☐ CEA/AMYLASE

☐ MRI/CT ☐ CYTOLOGY Not Performed ☐ CEA/AMYLASE Not Performed

CLINICAL FINDING (CYTOLOGY, CEA, EUS FEATURES, ETC) ARE OPTIMAL FOR THE HIGHEST ACCURACY OF AN INTEGRATED DIAGNOSTIC CATEGORY.

2. SUBMITTING DIAGNOSIS

ICD CODES (REQUIRED):

_____ _____ _____

_____ _____ _____

Please indicate ALL applicable diagnosis codes above. Possible codes for your consideration are listed below. DO NOT CIRCLE.

K86.2 Cyst of pancreas
K86.0 Chronic pancreatitis
K86.8 Other specified

K86.3 Pseudocyst of pancreas
K86.1 Other chronic pancreatitis

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.

3. REQUIRED FOR MEDICARE PATIENTS

If this test is ordered more than 14 days after discharge, you must identify factors that affected the time of ordering PancraGen.

REASON CODES

☐ 1. COMPLEX CASE required extensive review and deliberation
☐ 2. INCONCLUSIVE DIAGNOSIS after initial workup; molecular studies ordered for additional data
☐ 3. REVIEW OF INITIAL TEST RESULTS WITH PATIENT required prior to ordering additional studies
☐ 4. CONSULTATION WITH OTHER PHYSICIAN(S) required time to schedule and obtain their input
☐ 5. OTHER _____

4. PANCRAGEN™ MOLECULAR TESTING / SIGNATURE

PancraGen is a second-line, multi-variate assay that combines molecular analysis with first line test results (cytology, fluid chemistry, and imaging) to assess the malignant potential of pancreatic cysts. PancraGen is not indicated for cases where the cytology is positive for malignancy.

☐ **PancraGen™** ***- Powered by PathFinderTG***

☐ **GNAS (oncogene point mutational analysis)**

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 patient or referring physician has given consent to the test I have ordered.

PHYSICIAN SIGNATURE _____

DATE SIGNED _____ (MM/DD/YYYY) PRINT NAME _____

STAFF CONTACT _____

PHONE _____ FAX _____

6. PATIENT INFORMATION (may adhere patient label)

PATIENT NAME _____ (Last Name, First, MI)

DATE OF BIRTH _____ (MM/DD/YYYY) SEX: ☐ FEMALE ☐ MALE

SSN or MRN _____

7. BILLING INFORMATION

☐ PATIENT BILLING INFORMATION ATTACHED (Face Sheet, Photocopies of Cards, etc)

BILL TO:

☐ MEDICARE ☐ PRIVATE INSURANCE ☐ ORDERING INSTITUTION

☐ MEDICAID ☐ PATIENT PRE-PAY (US check, cert. funds, etc.)

INTERPACE DIAGNOSTICS WILL BILL DIRECTLY FOR COVERED PATIENTS, WHEREVER PERMITTED BY GOVERNMENT REGULATIONS, PAYER BILLING POLICIES, OR CONTRACTUAL ARRANGEMENTS. IF PATIENT OR INSURANCE INFORMATION IS NOT COMPLETED OR ATTCHED, YOUR FACILITY WILL BE BILLED.

8. PROCEDURE DETAILS

COLLECTION DATE _____ (MM/DD/YYYY) TIME _____ (HH:MM) ☐ AM ☐ PM

SPECIMEN COLLECTION SETTING

☐ HOSPITAL (INPATIENT): Date of Discharge _____ (MM/DD/YYYY)

☐ HOSPITAL (OUTPATIENT) ☐ NON-HOSPITAL AFFILIATED SETTING

9. SPECIMEN QUANTITIES

EACH VIAL MUST BE LABELED WITH SPECIMEN ID & TWO PATIENT IDENTIFIERS

☐ PANCREATIC CYST FLUID ☐ PANCREATIC DUCT FLUID

1. SPECIMEN ID _____
   Number of tubes submitted: ☐ 1 ☐ 2 ☐ 3 ☐ _____
2. SPECIMEN ID _____
   Number of tubes submitted: ☐ 1 ☐ 2 ☐ 3 ☐ _____
3. SPECIMEN ID _____
   Number of tubes submitted: ☐ 1 ☐ 2 ☐ 3 ☐ _____

SUBMITTED CONTROL REQUIRED:

☐ BUCCAL BRUSH or ☐ BLOOD (EDTA, ACD-A, or ACD-B tube)

10. PROVIDER INFORMATION

ORDERING INSTITUTION: _____

COLLECTING INSTITUTION: _____

ORDERING PHYSICIAN(S): NPI TEL FAX

FAX ADD'L REPORTS TO: _____