Phone 866.776.5907 / Fax 239.690.4237
neogenomics.com

InVisionFirst®-Lung Liquid Biopsy Requisition

Client Information

Required Information

Account #: _____ **Account Name:** _____

Street Address: _____

_____

City, ST, ZIP: _____

Phone: _____ **Fax:** _____

Additional Reporting Fax: _____

Requisition Completed by: _____ Date: _____

Ordering Physician (please print: Last, First): _____ **NPI #:** _____

Treating Physician (please print: Last, First): _____ NPI #: _____

The undersigned certifies that he/she is licensed to order the test(s) listed below and that such test(s) are medically necessary for the care/treatment of this patient. If ordering InVisionFirst®-Lung Liquid Biopsy, the undersigned additionally certifies that he/she understands Medicare's medical necessity criteria for the InVisionFirst®-Lung Liquid Biopsy test listed on the back of this form.

Authorized Signature: _____ **Date:** _____

Billing Information

Required: Please include face sheet and front/back of patient's insurance card for both primary and secondary insurance..

Patient Status (Must Choose 1):
- ☐ Hospital Patient (in)
- ☐ Hospital Patient (out)
- ☐ Non-Hospital Patient

Bill to: ☐ Client Bill ☐ Insurance ☐ Medicare ☐ Medicaid ☐ Patient/Self-Pay ☐ Bill charges to other Hospital/Facility: _____

ABN required for InVisionFirst®-Lung Liquid Biopsy on Medicare/Medicare Advantage patients who do not meet coverage criteria or when concurrent tissue molecular/liquid biopsy testing is ordered (see back). ABN attached ☐ Yes ☐ No

Prior Authorization # if required _____ See NeoGenomics.com billing section for more info.

Tissue Specimen Information

PATHOLOGY TO COMPLETE

Specimen ID: _____ **Block ID:** _____

Fixative/Preservative: _____ **Retrieved Date:** mm _____ / dd _____ / yyyy _____

Hospital Discharge Date: mm _____ / dd _____ / yyyy _____

Collection Date: mm _____ / dd _____ / yyyy _____ Collection Time: _____ ☐ AM ☐ PM

☐ Slides # _____ Unstained _____ Stained _____ ☐ H&E _____

☐ Primary ☐ Metastasis – If Metastasis, list Primary: _____

☐ Paraffin Block(s) #: _____ ☐ **Choose best block** (for global molecular/NGS testing only) Submit ≤4 FFPE blocks. Blocks will be combined for molecular testing when necessary.

Fixation Details:
Cold ischemic time ≤ 1 hour: ☐ Yes ☐ No ☐ Unknown
10% neutral buffered formalin: ☐ Yes ☐ No ☐ Unknown
HER2/ER/PgR Fixation duration 6 to 72 hours: ☐ Yes ☐ No ☐ Unknown

Patient Information

Last Name: _____ ☐ **Male** ☐ **Female**

First Name: _____ **M.I.** _____ Other Pt ID/Acct #: _____

Date of Birth: mm _____ / dd _____ / yyyy _____ Medical Record #: _____

By completing this section, Client represents it has obtained informed consent from patient to perform the services described herein.

Clinical Information

Required: Please attach patient's pathology report, clinical history, and other applicable report(s).

ICD 10 (Diagnosis) Code/Narrative (Required): _____

Reason for Referral: _____

☐ New Diagnosis ☐ Relapse ☐ In Remission ☐ Monitoring

Staging: ☐ 0 ☐ I ☐ II ☐ IIIA ☐ IIIB ☐ IV Note: _____

Blood Specimen Information

Specimen ID: _____

Hospital Discharge Date: mm _____ / dd _____ / yyyy _____

Collection Date: mm _____ / dd _____ / yyyy _____ Collection Time: ☐ AM ☐ PM

☐ Peripheral Blood: Streck Cell-Free DNA BCT®# _____

Mobile Phlebotomy Request

ONCOLOGY OFFICE TO COMPLETE IF NEEDED

Patient Phone (mobile preferred): _____

Patient Email (optional): _____

Patient Home Address: _____

City, ST, ZIP: _____

Order Liquid Biopsy below and **please fax** this completed requisition, pathology report, and face sheet or insurance information to 239.690.4237.

By completing this section, Client represents it has obtained patient's consent to be contacted by third-party service.

3rd Party Specimen Location

ONCOLOGY OFFICE TO COMPLETE & FAX

☐ **Client will arrange shipment of tissue.** Include a copy of this requisition with the tissue to prevent duplicate orders. **OR**

Complete the following for NeoGenomics to obtain tissue from Pathology site. **Please fax** this completed requisition, pathology report, and face sheet/insurance information to **239.690.4237.**

Location of Specimen: _____

Street Address: _____

_____

City: _____ **ST:** _____ **ZIP:** _____

Phone: _____ **Fax:** _____

Body Site: _____

Collection Date: mm _____ / dd _____ / yyyy _____

Liquid Biopsy Only

☐ **InVisionFirst®-Lung Liquid Biopsy** (Test upon receipt. More test details on back)

☐ **InVisionFirst®-Lung Liquid Biopsy, process and hold**

Liquid Biopsy + Tissue Testing

☐ **NeoTYPE® DNA & RNA – Lung* on tissue first, reflex to InVisionFirst®–Lung Liquid Biopsy** if tissue RNA and/or DNA is insufficient for NGS

☐ Add PD-L1 22C3 FDA for NSCLC IHC

☐ **InVisionFirst®–Lung Liquid Biopsy and tissue PD-L1 22C3 FDA for NSCLC IHC**

Complete 3rd Party Specimen Location above.

PD-L1 will report separately.

Specimen Requirements

InVisionFirst®– Lung Liquid Biopsy: Do not refrigerate. Special collection tubes and shipping requirements apply. Please contact Client Services for kits and see instructions provided in kit.

All other tests: Use cool pack during transport. Please call Client Services Team with any questions regarding specimen requirements or shipping instructions at 866.776.5907 option 1. Please refer to the website for specific details on each specimen.

Additional Billing Information

Any organization referring specimens for testing services pursuant to this Requisition Form ("Client") expressly agrees to the following terms and conditions.

1. **Binding Service Order.** This Requisition Form is a contractually binding order for the services ordered hereunder ("Services") and Client agrees that it is financially responsible for all tests billable to Client hereunder.
2. **Third Party Billing by NeoGenomics and Right to Bill Client.** Client agrees to accurately indicate on the front of the Requisition Form that either Client should be billed (e.g., Client receives reimbursement pursuant to a non-fee-for-service basis, including, but not limited to, a capitated, diagnostic related group ("DRG"), per diem, all-inclusive, or other such bundled or consolidated billing arrangement) or NeoGenomics should bill the applicable federal, state or commercial health insurer or other third party payer (collectively, "Payers") for all Services ordered pursuant to this Requisition Form. For all such Services billable to Payers, Client agrees to provide all billing information necessary for NeoGenomics to bill such payer. In the event NeoGenomics: (i) does not receive the billing information required for it to bill any Payers within ten days of the date that any Services are reported by NeoGenomics; (ii) the Services were performed for patients who have no Payer coverage arrangements; or (iii) the Payer identified by Client denies financial responsibility for the Services and indicates that Client is financially responsible, NeoGenomics shall have the right to bill such Services to Client.

InVisionFirst®-Lung Liquid Biopsy Conditions for Medicare Coverage

InVisionFirst®-Lung Liquid Biopsy is a plasma-based, somatic comprehensive genomic profiling test (CGP) intended to assist physicians caring for patients with advanced (Stage IIIB/IV) non-small cell lung cancer (NSCLC). In accordance with Medicare's MolDX Noridian LCD L37897, testing is appropriate under the following circumstances:

At diagnosis and untreated: When results for EGFR single nucleotide variants (SNVs) and insertions and deletions (indels); rearrangements in ALK and ROS1; and SNVs for BRAF are not available AND when tissue-based CGP is infeasible [i.e., quantity not sufficient (QNS) for tissue-based CGP or invasive biopsy is medically contraindicated] **OR**

At progression: For patients progressing on or after chemotherapy or immunotherapy who have not been tested for EGFR SNVs and indels; rearrangements in ALK and ROS1; and SNVs for BRAF, and for whom tissue-based CGP is infeasible; or for patients progressing on EGFR tyrosine kinase inhibitors (TKIs).

A patient signed ABN is required if patient does not meet the coverage criteria. ABN is also required if ordering InVisionFirst®-Lung Liquid Biopsy concurrently with tissue testing that includes EGFR, BRAF, ALK, and ROS1.

Test Descriptions

Please see complete test descriptions and all available tests at our website, www.neogenomics.com.

Test Notations

Specimen Usage

NeoGenomics makes every effort to preserve and not exhaust tissue, but in small and thin specimens, there is a possibility of exhausting the specimen in order to ensure adequate material and reliable results.

InVisionFirst®-Lung Liquid Biopsy

InVisionFirst®-Lung Liquid Biopsy testing is performed by Inivata, Inc., a subsidiary of NeoGenomics Laboratories. See www.neogenomics.com for test details.

NeoTYPE® DNA & RNA – Lung

If the sample is insufficient to produce both DNA and RNA results, the available results will be reported and alternate CPT® Codes may apply. Please see website for details.

For our complete test menu, TAT, specimen requirements and more, please visit: neogenomics.com/test-menu

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