MOLECULAR PATHOLOGY

SAMPLE TYPE

- Peripheral Blood
- Bone Marrow Aspirate
- Fresh Tissue; site __________
- Paraffin Block; site __________
- Fluid; type __________
- Slides; site __________
- Block No. __________
- Slide No. __________

CLINICAL HISTORY

Signs/Symptoms: ____________________________________
Prior Diagnosis____________________________________
Suspected Diagnosis________________________________

MOLECULAR PATHOLOGY

- Alpha Thalassemia/Hb Constant Spring
- AML Prognosis Assay- NMP1 & FLT3
- B-Cell Clonality Include Pathology report
- BCR-ABL
- BCR-ABL Kinase Domain Mutation Analysis
- Beta Thalassemia Sequencing
- BRAF by PCR Include Pathology report
- Calreticulin Mutation Detection
- CEBPA by sequencing
- IDH1/IDH2 Mutation Panel Include Pathology report
- KIT Mutation Analysis(exons 8 & 17)
- KIT D816V Include Pathology report
- Factor V Leiden
- Familiar Gastric Cancer (CDH1) by sequencing, Blood or FFPE Normal Tissue
- Familial Gastric Cancer (CDH1), Blood or FFPE Normal Tissue
  Known Mutation, Exon:__________
- Familial Gastric Cancer (CDH1 deletion/duplication analysis) by MLPA, Blood
  (complete CDH1 requisition)
  CDH1 requisition can be found at http://www.stanfordlab.com/pages/test_requisitions.htm

- JAK2 V617F (1849G>T), Quantitative
- KRAS/NRAS Mutation Detection Include Pathology report
- Stanford Solid Tumor Actionable Mutation Panel by Next Gen Seq. Include Pathology report
- MGMT by Methylation Specific PCR
- MYD88 Mutation L265P, 794T>C
- Prothrombin-20210A Mutation
- SF3B1 Mutation
- T-Cell Clonality by PCR Include Pathology report
- VH Mutation Analysis
- Microsatellite Instability by PCR Check if whole blood submitted

- IDH1/IDH2 Mutation Panel Include Pathology report
- KIT Mutation Analysis(exons 8 & 17)
- KIT D816V Include Pathology report
- Factor V Leiden
- Familiar Gastric Cancer (CDH1) by sequencing, Blood or FFPE Normal Tissue
- Familial Gastric Cancer (CDH1), Blood or FFPE Normal Tissue
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- JAK2 V617F (1849G>T), Quantitative
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- T-Cell Clonality by PCR Include Pathology report
- VH Mutation Analysis
- Microsatellite Instability by PCR Check if whole blood submitted

- Known Mutation, Exon:__________
- Familial Gastric Cancer (CDH1 deletion/duplication analysis) by MLPA, Blood
  (complete CDH1 requisition)
  CDH1 requisition can be found at http://www.stanfordlab.com/pages/test_requisitions.htm

RNA Studies –ship on wet ice
Provide the % neoplastic cells in sample submitted
Provide the % tumor in sample submitted
A full list of targeted regions for the Sequencing Assays can be found at www.stanfordlab.com

Each individual test and CMS approved panel must have ICD code(s) to indicate the medical necessity of the test requested. Please provide all applicable ICD code(s) for the tests ordered. @ Tests for Medicare Patients Must be screened to determine if an Advanced Beneficiary Notice (ABN) is required. An ABN must be provided to the Medicare patient if there is a reason to believe Medicare will deny the test. Medicare may deny tests due to frequency. Medicare does not generally cover routine screening tests. Continued on page 3.

ICD Code(s) * - REQUIRED INFORMATION

Physician Signature: __________________________ Date: ________ Time: ____________

Each individual test and CMS approved panel must have ICD code(s) to indicate the medical necessity of the test requested. Please provide all applicable ICD code(s) for the tests ordered. @ Tests for Medicare Patients Must be screened to determine if an Advanced Beneficiary Notice (ABN) is required. An ABN must be provided to the Medicare patient if there is a reason to believe Medicare will deny the test. Medicare may deny tests due to frequency. Medicare does not generally cover routine screening tests. Continued on page 3.
For Lab Use Only

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Ordering Physician Name</th>
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<tr>
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<table>
<thead>
<tr>
<th>Address</th>
<th>Physician NPI No.</th>
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<tbody>
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<table>
<thead>
<tr>
<th>City, State, Zip</th>
<th>Physician Phone No.</th>
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<th>Facility Phone Number</th>
<th>Report Fax Number</th>
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<table>
<thead>
<tr>
<th>Patient Name (Last)</th>
<th>(First)</th>
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<tbody>
<tr>
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<tr>
<th>Insurance Info:</th>
<th>Attach a copy of front &amp; back of Insurance card or face sheet</th>
</tr>
</thead>
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<td></td>
<td>□ Private Ins/PPO □ Medicare □ Medi-Cal □ Patient □ Client</td>
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<tr>
<th>Unique ID or MRN</th>
<th>DOB-Required</th>
<th>Sex</th>
<th>Responsible Party (Please Print)</th>
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<td></td>
<td>M F</td>
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<tr>
<th>Patient's Phone Number</th>
<th>Collection Date &amp; Time</th>
<th>Collection by-</th>
<th>Address</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Required</td>
<td></td>
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</table>

Copy to: | First Name | Last Name | City, State, Zip |

Copy to complete address for mailing:

ICD Code(s) * - REQUIRED INFORMATION

<table>
<thead>
<tr>
<th>Physician Signature:</th>
<th>Date:</th>
<th>Time:</th>
</tr>
</thead>
</table>

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SAMPLE TYPE

- □ Peripheral Blood
- □ Fluid; type ___________
- □ Fresh Tissue; site __________ Type __________
- □ Paraffin Block; site __________ Block No. __________

CLINICAL HISTORY

Signs/Symptoms: ____________________________

Suspected Diagnosis: ____________________________

Prior Diagnosis: ____________________________

MOLECULAR PATHOLOGY

<table>
<thead>
<tr>
<th>Test Name</th>
<th>Test Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Achondroplasia / Hypochondroplasia</td>
<td>□ FGFRI Craniosynostosis</td>
</tr>
<tr>
<td>□ Alpha Thalassemia/Hb Constant Spring</td>
<td>□ FGFRII Craniosynostosis</td>
</tr>
<tr>
<td>□ Beta Thalassemia Sequencing</td>
<td>□ FGFRIII Muenke</td>
</tr>
<tr>
<td>□ Biotinidase Sequencing Assay</td>
<td>□ Fragile X</td>
</tr>
<tr>
<td>□ CF 39, Cystic Fibrosis, DNA</td>
<td>□ Hemochromatosis Genotyping Analysis</td>
</tr>
<tr>
<td>□ CF Poly-T Analysis</td>
<td>□ Huntington Disease Analysis</td>
</tr>
<tr>
<td>□ CFTR Screen by Sequencing (Unidirectional)</td>
<td>□ Pendred Syndrome by sequencing</td>
</tr>
<tr>
<td>□ CFTR Deletion/Duplication Analysis by MLPA</td>
<td>□ Prader-Willi Syndrome (PWS), RNA</td>
</tr>
<tr>
<td>□ CFTR Diagnostic Sequencing (Bidirectional DNA Full gene)</td>
<td>□ Prothrombin-20210A Mutation</td>
</tr>
<tr>
<td>□ CFTR Sequencing Assay, Exon specific</td>
<td>□ Maternal Cell Contamination-Fetal Sample and Maternal Cell Contamination- Whole Blood Maternal Sample (4mL EDTA) required with prenatal sample.</td>
</tr>
</tbody>
</table>

List mutation(s): ____________________________

- □ Connexin 26, Sequencing
- □ Connexin 30
- □ Duchenne and Becker Muscular Dystrophy by MLPA
- □ Factor V Leiden
- □ Familial Gastric Cancer (CDH1) by sequencing □ Extract DNA for future testing
- □ Whole Blood or FFPE Normal Tissue
- □ Familial Gastric Cancer (CDH1) Known Mutation, □ Extract RNA for future testing
- □ Whole Blood or FFPE Normal Tissue
- □ Familial Gastric Cancer (CDH1) by sequencing (CDH1 deletion/duplication analysis) by MLPA

- □ Factor V Leiden

- □ RNA studies ship on wet ice
- □ Complete CDH1 requisition CDH1 requisition can be found at http://www.stanfordlab.com/pages/test_requisitions.htm
MOLECULAR PATHOLOGY

SAMPLE TYPE

- Peripheral Blood
- Fluid; type ___________
- Fresh Tissue; site __________ Type ___________
- Paraffin Block; site __________ Block No. ___________

CLINICAL HISTORY

Signs/Symptoms:  __________________________________
Prior Diagnosis____________________________________
Suspected Diagnosis:________________________________

MOLECULAR PATHOLOGY

√ Test Name √ Test Name
- Achondroplasia / Hypochondroplasia
- FGFR1 Craniosynostosis
- Alpha Thalassemia/Hb Constant Spring
- FGFR2 Craniosynostosis
- Beta Thalassemia Sequencing
- FGFR3 Muenke
- Biotinidase Sequencing Assay
- Fragile X
- CF 39, Cystic Fibrosis, DNA
- Hemochromatosis Genotyping Analysis
- CF Poly-T Analysis
- Huntington Disease Analysis
- CFTR Screen by Sequencing (Unidirectional)
- Pendred Syndrome by sequencing
- CFTR Deletion/Duplication Analysis by MLPA
- Prader-Willi Syndrome (PWS), RNA
- CFTR Diagnostic Sequencing (Bidirectional DNA Full gene)
- Prothrombin-20210A Mutation
- CFTR Sequencing Assay, Exon specific
- Maternal Cell Contamination-Fetal Sample and List mutation(s):  ______________________________  Maternal Cell Contamination-
- Whole Blood
- Connexin 26, Sequencing
- Connexin 30
- Extract DNA for future testing
- Duchenne and Becker Muscular Dystrophy by MLPA
- Extract RNA for future testing
- Factor V Leiden
- Other:  _________________________________
- Familial Gastric Cancer (CDH1) by sequencing
- Familial Gastric Cancer, Whole Blood (CDH1 deletion/duplication analysis) by MLPA
- Familial Gastric Cancer (CDH1) Known Mutation, Whole Blood or FFPE Normal Tissue Exon:_________________
- RNA studies ship on wet ice
- Complete CDH1 requisition
- CDH1 requisition can be found at http://www.stanfordlab.com/pages/test_requisitions.htm

STANFORD SPECIMEN REQUIREMENTS

For Specimen collection questions you may call the testing laboratory at the phone number listed next to the department name or contact our Customer Service department at 1-877-717-3733. Specimen requirements can also be found on www.stanfordlab.com.

MOLECULAR PATHOLOGY

<table>
<thead>
<tr>
<th>Whole Blood</th>
<th>Lab Phone Number (650) 723-6574</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Minimum 4 mL</td>
<td></td>
</tr>
<tr>
<td>• Lavender-top (EDTA) tubes</td>
<td></td>
</tr>
<tr>
<td>RNA Studies -ship on wet ice, DNA Studies ship at room temperature</td>
<td></td>
</tr>
<tr>
<td>■ Provide % neoplastic cells in sample submitted</td>
<td></td>
</tr>
<tr>
<td>Bone Marrow</td>
<td></td>
</tr>
<tr>
<td>• 1-2 mL Bone Marrow</td>
<td></td>
</tr>
<tr>
<td>• Lavender-top (EDTA) tubes</td>
<td></td>
</tr>
<tr>
<td>• Maintain specimen at room temperature</td>
<td></td>
</tr>
<tr>
<td>■ Provide % neoplastic cells in sample submitted</td>
<td></td>
</tr>
<tr>
<td>Tissue</td>
<td></td>
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<tr>
<td>Envelope a copy of the patient's Pathology Report</td>
<td></td>
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<tr>
<td>• Non-decalcified formalin-fixed, paraffin-embedded (FFPE) at room temperature</td>
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</tr>
<tr>
<td>• Provide % tumor in sample submitted or H &amp; E stained slide of block submitted</td>
<td></td>
</tr>
<tr>
<td>Fluid</td>
<td></td>
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<tr>
<td>• Volume varies, contact laboratory</td>
<td></td>
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<tr>
<td>• Sterile tube</td>
<td></td>
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<tr>
<td>• Maintain specimen at room temperature</td>
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</tbody>
</table>

Ship to: Stanford Anatomic Pathology and Clinical Laboratories
If shipping Friday check for Saturday delivery
Phone: 1 (877) 717-3733
Fax delivery notification to: (650) 724-4758

Shipper’s Responsibility: The shipper is required to comply with the rules and guidelines for transport of medical specimens as set forth by the United States government, the government of the country of origin and international regulatory agencies. Failure to follow instructions for packaging and shipping specimens can result in the delay, loss or destruction of your specimens. Stanford University Medical Center Clinical Laboratories will not be held responsible for any liability attributable to the shipper’s improper actions or failure to comply with regulations.

Continued from page 1 or 2
Section 1862(a)(1)(A) of the Social Security Act states, “no payment may be made under Part A or Part B for any expense incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of any illness or to improve the functioning of a malformed body member.” Tests submitted for Medicare reimbursement must meet program requirements or the claim may be denied.
@ This test is subject to Medicare NCD or LCD, coverage is limited to certain diagnoses that support medical necessity.
* ICD Code(s) based on present CMS guidelines.
Advance Beneficiary Notice of Noncoverage (ABN)

**NOTE:** If Medicare doesn’t pay for **D.** below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** below.

<table>
<thead>
<tr>
<th>D.</th>
<th>E. Reason Medicare May Not Pay</th>
<th>F. Estimated Cost</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

**WHAT YOU NEED TO DO NOW:**
- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** listed above.

**Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

**G. OPTIONS:** Check only one box. We cannot choose a box for you.

- **☐ OPTION 1.** I want the **D.** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn’t pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

- **☐ OPTION 2.** I want the **D.** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

- **☐ OPTION 3.** I don’t want the **D.** listed above. I understand with this choice I am **not responsible for payment** and **I cannot appeal to see if Medicare would pay.**

**H. Additional Information:**

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

**I. Signature:**

**J. Date:**

---

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (03/11)