OncoPrism®-HNSCC Requisition Form CT072503

COFACTOR genomics

OncoPrism® MULTIDIMENSIONAL PREDICTION
CFG ID # (entered by CFG)

Complete and send to Cofactor Genomics by either fax to +1 (844) 328-5841 or to the secure email address oncoprism@cofactorgenomics.com

REQUIRED: Please Include with requisition to Cofactor Genomics:

1- Patient's Face Sheet from Medical Record

2- Front and back of the patient's insurance card(s)

3- Completed and signed physician's order for OncoPrism laboratory testing

For assistance, visit support.cofactorgenomics.com, email support@cofactorgenomics.com, or call +1 (240) 534-1241. Additional details and instructions for completing this OncoPrism-HNSCC testing form are in the OncoPrism Collection Kit.

1. Physician Information

Physician Name	NPI
Email	FAX
Institution Name	
Institution Address	
Contact Name & Phone	
Contact Email	**Testing Results sent to fax number or secure email address provided**

2. Physician Authorization and Signature

I certify that the patient specified above and/or their legal guardian has been informed of the benefits, risks, and limitations of Cofactor Genomics OncoPrism laboratory testing and informed consent has been obtained, as well as any other consent required by my state in order to perform a genetic test on a specimen. I further certify that the test requested is medically necessary and the results of this test will be used in the medical management of the patient. I agree to provide the necessary patient information and medical records required to support billing or reimbursement to Cofactor Genomics.

Printed Physician Name	Signature	Date

3. Clinical Information

Patient MRN				
ICD-10 HNSCC Diagnosis Code(s)				
HNSCC disease status (check below)				
☐ recurrent	☐ metastatic			
Previous treatment for R/M disease (check below all applicable)				
☐ none	☐ radiotherapy	☐ taxane	☐ platinum	
☐ immunotherapy	☐ cetuximab	☐ other		
PD-L1 status (CPS)	☐ unknown	☐ 0	☐ 1-19	☐ 20+

4. Specimen Information

Pathology Lab and Contact		
Email	Phone	FAX
Accession #	Biopsy Date	
Anatomical Site of Biopsy	**Testing Results sent to fax number or secure email address provided**	

Non-decalcified Formalin Fixed Paraffin Embedded (FFPE) tissue provided as one of the designs below:

a) 6 unstained charged slides (5 microns thick) OR

b) 2 unstained charged slides (5 microns thick) AND 2 curls (10 microns thick) OR

c) Other (specify):

Samples collected from bone or liver are not acceptable. Samples must have been collected within the last 2 years. Patient must have a recurrent and/or metastatic head and neck squamous cell carcinoma diagnosis.

5. Patient Identification Information

Name: First	Middle	Last
Date of Birth		Sex

6. Patient Billing Information

Patient Status (Chose only 1)	☐ Hospital Patient (In)	☐ Hospital patient (out)	☐ Non-Hospital Patient

INCLUDE A COPY OF PATIENT'S FACE SHEET AND INSURANCE CARD(S) WITH THIS REQUISITION
IF THE DOCUMENTS STATED ABOVE ARE NOT AVAILABLE TO SEND, PLEASE FILL OUT THE SECTION BELOW

Patient Phone Number		Street Address		City State Zip Code		
Insurance Type: (check all that apply)	☐ Medicaid	☐ Medicare	☐ Private Insurance	☐ Hospital/Institution	☐ Veterans Administration	☐ Self-Pay/ Other
Primary Insurance Name				Policy Dates		
Policy Number				Group Number		
Secondary Insurance Name				Policy Dates		
Policy Number				Group Number		
Patient Relationship to Insured:	☐ Self	☐ Spouse		☐ Child	☐ Other:	
If not self, please provide the following information for the main policy holder:						
Policy Holder's Name			Date of Birth		Phone	