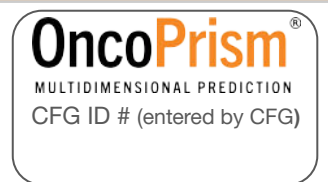


OncoPrism[®]-HNSCC Requisition Form CT072606



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			2. Physician Authorization and Signature		
Physician Name	NPI	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.			
Email	FAX				
Institution Name					
Institution Address					
Contact Name & Phone		Printed Physician Name		Signature	Date
Contact Email	Testing Results sent to fax number or secure email address provided		4. Specimen Information		
3. Clinical Information			Pathology Lab and Contact		
Patient MRN			Email		Phone
ICD-10 HNSCC Diagnosis Code(s)			Accession #		FAX
HNSCC disease status (check below)			Biopsy Date		
<input type="checkbox"/> recurrent <input type="checkbox"/> metastatic			Anatomical Site of Biopsy		Testing Results sent to fax number or secure email address provided
Previous treatment for R/M disease (check all that apply below)			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):		
<input type="checkbox"/> none <input type="checkbox"/> radiotherapy <input type="checkbox"/> taxane <input type="checkbox"/> platinum					
<input type="checkbox"/> immunotherapy <input type="checkbox"/> cetuximab <input type="checkbox"/> other					
PD-L1 status (CPS) <input type="checkbox"/> unknown <input type="checkbox"/> 0 <input type="checkbox"/> 1-19 <input type="checkbox"/> 20+			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 (Choose only 1)		<input type="checkbox"/> Hospital Patient (In) <input type="checkbox"/> Hospital patient (out)		<input type="checkbox"/> 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)		<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private Insurance		<input type="checkbox"/> Hospital/Institution <input type="checkbox"/> Veterans Administration <input type="checkbox"/> 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:		<input type="checkbox"/> Self <input type="checkbox"/> Spouse		<input type="checkbox"/> Child <input type="checkbox"/> Other:	
If not self, please provide the following information for the main policy holder:					
Policy Holder's Name			Date of Birth		Phone