InVision First LUNG Clinical Test Requisition Form

Inivata

For Inivata Use Only

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(919) 371-5143
client.services@inivata.com

FOR COLLECTION SITE USE

Blood Draw Date:

Time:

PATIENT INFORMATION

Patient Name (Last, First MI)

Date of Birth (mm/dd/yyyy) ○ Male ○ Female

Medical Record Number/Patient ID

Address | City | State | ZIP

Area Code | Phone Number

TEST & INTENDED USE

Test: InVision First LUNG

Submitting Diagnosis ○ NSCLC

NSCLC Stage ○ Stage IIIB ○ Stage IIIC ○ Stage IVA ○ Stage IVB

ICD-10 Code

Testing History: *(Please include pathology report with order)*

○ At Diagnosis

○ When results for EGFR single nucleotide variants (SNVs) and insertions and deletions (indels); rearragements 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 comprehensive genomic profiling (CGP) is infeasible

○ Patient progressing on EGFR tyrosine kinase inhibitors (TKIs)

Targeted Therapy Prescribed

BILLING INFORMATION

Billing Type

○ Private Insurance
○ Patient Pay (Inivata will contact Office)
○ Bill Hospital (Contract must be in place)
○ Medicaid
○ Medicare

Hospital Status at Time of Specimen Collection (Medicare Only)

Inpatient ○ No ○ Yes

If "Yes," Discharge Date

INSURANCE INFORMATION

Primary Insurance

Insurance Name | Insurance Member ID

Insurance Policy Holder Name | Prior Authorization Number

Secondary Insurance

Insurance Name | Insurance Member ID

Insurance Policy Holder Name | Prior Authorization Number

ORDERING PHYSICIAN & ATTESTATION

Ordering Physician

Hospital/Practice Name | NPI #

Address | City | State | ZIP

Physician Administrative Contact Name

Email Address

Phone Number: Area Code | Phone Number

Fax Number: Area Code | Fax Number

Ordering Physician Attestation:

My signature constitutes a Certificate of Medical Necessity and certifies that I have explained to the patient the nature and purpose of the testing to be performed and have obtained informed consent, to the extent legally required, to permit Inivata to (a) perform the testing specified herein, (b) retain the test results for an indefinite period for internal quality assurance/operations purposes, (c) de-identifiy the test results and use or disclose such de-identified results for future unspecified research or other purposes, and (d) release the test results to the patient's insurance as needed for reimbursement purposes.

Ordering Physician Signature | Date

Print Ordering Physician Name

This test was developed and its performance characteristics determined by Inivata. It has not been cleared or approved by the U.S. Food and Drug Administration.