ARIEL

FAX TO:
(844) 692-7435

Ariel Precision Medicine
5750 Centre Avenue, Suite 270 Pittsburgh, PA 15206
844.692.7435 | info@arielmedicine.com | www.arielmedicine.com
Doc. No. AR-015-01

Genetic Test Requisition Form

Please select one or both of the following core testing panels:

☐ ***ArielDx® Pancreatitis*** — A 12-gene next-generation sequencing panel for pancreatitis. This test represents sequencing and deletion/duplication studies of *CASR*, *CEL*, *CFTR*, *CPA1*, *CTRC*, *GGT1*, *PRSS1*, *PRSS2*, *PRSS3*, *SBDS*, *SPINK1* and *UBR1*, as well as sequencing of two regions of interest near *CLDN2* and a region of interest in *SLC26A9*.

***Primary Indication for Testing (include ICD-10 code for insurance billing):** _____
Additional Indications for Testing (include ICD-10 code(s) if known): _____

☐ ***ArielDx® Pancreatic Cancer*** — A 14-gene next-generation sequencing panel to evaluate genes associated with a hereditary susceptibility for pancreatic cancer. This test represents sequencing and deletion/duplication studies of *APC*, *ATM*, *BRCA1*, *BRCA2*, *CDKN2A*, *EPCAM**, *MLH1*, *MSH2*, *MSH6*, *PALB2*, *PMS2*, *PRSS1*, *STK11*, and *TP53*. *deletion/duplication studies only

***Primary Indication for Testing (include ICD-10 code for insurance billing):** _____
Additional Indications for Testing (include ICD-10 code(s) if known): _____

Please select if you would like to include any of the following add-on panels:

☐ ***ArielDx® Lipids*** — A next-generation sequencing panel for genes associated with abnormal lipid metabolism that may increase risk of pancreatitis. Genes reported include: *APOA5*, *APOC2*, *FABP4*, *GPIHBP1*, *LMF1*, *LPL*, *PPARG* and a region of interest in *APOB* exon 29.

☐ ***ArielDx® Pharmacogenomics*** — A next-generation sequencing based pharmacogenomics panel that tests for 30 genes related to drug metabolism, action, side effects, and/or toxicity. Results can be used to support safe and effective use of medications for current and future clinical care. A full list of genes that are tested is available at arielmedicine.com/pgx.

This information is used to register the patient's sample collection kit. Please ensure that this information is up to date. An email address must be provided for each patient.

Name (First & Last)	Date of Birth (MM/DD/YYYY)
Email (EX: "patient@mail.com")	Phone (###-###-####)

If the patient does **not** have an email address, please include a physical mailing address:

Address Line 1	City	State
Address Line 2	ZIP	

Please indicate the patient's preferred language: ☐ ***English*** ☐ ***Spanish***

1 Genetic Counseling Opt-Out

Ariel Precision Medicine offers pre-test genetic counseling to our patients included with the test. We can also facilitate a post-test counseling session, billed either through the patient's insurance or directly to the patient. Genetic counseling is strongly recommended.

If ***ArielDx® Pancreatic Cancer*** is ordered:
Several insurance providers require pre-test genetic counseling and documentation for coverage of cancer genetic testing. Please provide the appropriate documentation below if you choose to opt of genetic counseling for ***ArielDx® Pancreatic Cancer***. You can also upload or fax this documentation at a later time. Ariel will reach out to your office to acquire any additional required documentation prior to genetic testing.

☐	Initials: _____	By checking this box, you are choosing to opt-out of genetic counseling services provided by Ariel Precision Medicine.

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2 Non-Malignant Pancreatic Disease

Skip to next section if ArielDx Pancreatitis was not ordered **AND** there is no personal history of pancreatitis or other non-malignant pancreatic disease.

Clinical History of Non-Malignant Pancreatic Disease (check all that apply):

- ☐ Acute Pancreatitis (AP)
- ☐ Recurrent?
  - Age of intial attack: _____
  - Frequency of attacks: _____
- ☐ Chronic Pancreatitis (CP)
  - Age of intial diagnosis:_____

If patient has pancreatitis, select the relevant etiology/etiologies:

- ☐ Idiopathic
- ☐ Biliary
- ☐ Alcohol-related
- ☐ Drug-induced
- ☐ Hereditary/Familial - Explain: _____
- ☐ Hypertriglyceridemia
  - Peak Triglyceride Levels: _____
- ☐ Other - Explain: _____

- ☐ Diabetes
  - Type (i.e. Type 1, Type 2, Type 3c): _____
  - Age of Diagnosis: _____
- ☐ Exocrine Pancreatic Insuffiency (EPI)
  - Age of Diagnosis: _____
- ☐ Cystic Fibrosis/CFTR-Related Disorder
  - Explain: _____
- ☐ Pancreas Divisum
- ☐ Sphincter of Oddi Dysfunction

3 Personal History of Cancer

Skip to next section if ArielDx Pancreatic Cancer was not ordered **AND** there is no personal history of cancer or polyps.

☐ ***Patient has known history of cancer or polyps***

☐ ***Patient has no known history of cancer or polyps*** *(skip to "Pancreatic Cancer Risk Factors")*

Pancreatic Cancer

Age at diagnosis: _____

- ☐ Ductal adenocarcinoma (PDAC)
- ☐ Neuroendocrine tumor
- ☐ Other: _____
- ☐ Cyst
- ☐ IPMN

Ovarian Cancer

Age at diagnosis: _____

Type/pathology: _____

Colorectal Cancer

Age at diagnosis: _____

Type: _____

- ☐ Tumor is MSI-High or IHC-Abnormal
  - Details: _____

Breast Cancer

Age at diagnosis: ___

- ☐ DCIS
- ☐ LCIS
- ☐ Ductal Invasive
- ☐ Lobular Invasive
- ☐ Bilateral
- ☐ Two primaries

Indicate (+), (-), or unk: ER:_____ PR:_____ HER2:_____

GI Polyps

Age at first diagnosis: _____

Type: _____ Number: _____

Other Cancer

Age at diagnosis: _____

Diagnosis: _____ Type: _____

Pathology: _____

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Pancreatic Cancer Risk Factors

- ☐ Tobacco
  - ☐ Previous Smoker
  - ☐ Current Smoker
    - Packs per day: _____
    - Pack years: _____
- ☐ Alcohol
  - ☐ Previous Drinker
  - ☐ Current Drinker
  - ☐ History of heavy alcohol use
    - Explain: _____
- ☐ Obesity (BMI > 30)
- ☐ Unexplained weight loss
- ☐ *H. pylori* infection

If the patient has a history of the following, **please complete Section 2 above ("Non-Malignant Pancreatic Disease")**:

- ☐ Pancreatitis
- ☐ Diabetes
- ☐ Other pancreatic disease

4 Family History

Provide information on relevant family history, including pancreatitis (specify chronic or acute, if known), cystic fibrosis or CF-related disorders, diabetes, pancreatic cancer, or other cancers, tumors or polyps). If either box below is checked, skip to the next section. If you run out of space, please include information on an additional page. If a family member has undergone genetic testing for pancreatitis, cystic fibrosis, pancreatic cancer, or related conditions, please specify the relationship to the patient, test and findings in Section 7. Attach the results, if available.

☐ ***No known family history***

☐ ***Unknown / Adopted***

Relationship to Patient	Maternal / Paternal	Condition	Age

5 Medications

Please detail the medication, dose, frequency, route of administration, and current/past. If you run out of space, please include information on an additional page.

Medication	Dose	Frequency	Route of administration	Current or past?

6 Prior Genetic Testing

☐ ***No prior testing (skip to next section)***

☐ ***Prior genes tested:*** _____

Attach copies of all genetic testing results if available.

For results, format as: (Gene | c.XXXX | p.XXXX | Pathogenic vs VUS | germline vs. somatic)

_____

_____

_____

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7 Additional Information

Please attach or detail below any additional clinical information that supports this patient's analysis, such as any complications of current conditions, surgical or endoscopic history, or previous treatments. If you run out of space, please include information on an additional page.

☐ ***Personal history of allogeneic bone marrow transplant***

8 Referring Physician

Physician Name (print)	Physician Phone (###-###-####)
Physician Address Line 1	Physician Fax (###-###-####)
Physician Address Line 2	Institution
Physician Email (EX: "doctor@mail.com")	

Genetic Counselor / Lab Contact Name (print)	Genetic Counselor / Lab Contact Phone (###-###-####)
Genetic Counselor / Lab Contact Email (EX: "genetic_counselor@mail.com")	Genetic Counselor / Lab Contact Fax (###-###-####)

9 Medical Necessity and Signature

☐ By checking this box, I affirm the undersigned person (or representative thereof) ensures he/she is a licensed medical professional authorized to order genetic testing and confirm the patient has given appropriate consent. I confirm that testing is medically necessary and that test results may impact medical management for the patient. Furthermore, all information on this order form is true to the best of my knowledge. I have attached a Letter of Medical Necessity (LMN) and/or other documentation for insurance billing purposes.

I agree to allow Ariel Precision Medicine to transfer this information, and any attached information, from this requisition for a LMN using the ordering physician's name as the signature for insurance billing.

Name (print)	Title	Date (MM/DD/YYYY)
Signature	Degree	NPI #