AlloSure LUNG®

PLACE ACCESSION LABEL HERE

AlloSure for Lung Transplant Test Requisition Form

If you need help finding a blood draw center for AlloSure Lung, call 1-888-255-6627.

All items in red are required. Missing information may delay testing.

Ordering Physician: Complete sections A, B, C, D, E, F (for additional comments) and G.
Phlebotomists: Complete red boxes, right, with draw site, draw date, and your initials.
Lab: Affix first accession label from tube and accession labels card in top right corner, as indicated.

DRAW SITE NAME		
DRAW DATE	COLLECTION TIME ☐am ☐pm	PHLEBO INITIALS

Numbered rows 1-9 and 11 contain fields that MUST be completed. MISSING INFORMATION MAY DELAY TESTING.

A. PATIENT AND PRESCRIBER INFORMATION

1	Patient Last Name	Patient First Name	MI ☐n/a	Unique Patient Identifier (e.g., MRN)	
2	DOB (mm/dd/yyyy)	Biological Sex: ☐Male ☐Female	Is this patient a multi-organ recipient? ☐No ☐Yes (STOP-Test is not intended for multi-organ transplant recipients. Please contact Customer Care to discuss options.)	Patient's Primary Phone	
3	Patient's Address	City	State	Zip	Patient's Email
4	Ordering Physician	NPI			

B. CLINICAL INFORMATION

5	Transplant Date (mm/dd/yyyy)	ICD-10 code: ☐T86.810-Lung Transplant Rejection ☐Z94.2-Lung Transplant Status ☐Other:
6	Reason for Ordering Test (choose one): ☐FOR CAUSE testing to further inform on the need for a biopsy, OR in lieu of biopsy, OR to further inform on the results of biopsy. No biopsy will be performed simultaneously with the test. ☐SURVEILLANCE testing where the patient would otherwise receive a surveillance (protocol) biopsy. ☐OTHER. Reason for test:	
7	**CHOOSE ONE**: ☐Single ☐Bilateral lung transplant	☐ **HOSPITAL DRAW ONLY:** Check if this is an inpatient, if testing order is <14 days from inpatient discharge, and/or if patient coverage is under private insurance case rate. In such cases, the hospital may be billed for the test.

C. ORDER FREQUENCY

8	**Check appropriate order schedule (choose one). Order may not exceed 12 months.** ☐Single Order ☐Custom Order (complete section below): *For changes to the above, after submission of this order, please call CareDx at 1-888-255-6627 or email at CustomerCare@CareDx.com.*												Start Date (mm/dd/yyyy)		
	☐ Month 0	☐ Month 1	☐ Month 2	☐ Month 3	☐ Month 4	☐ Month 5	☐ Month 6	☐ Month 7	☐ Month 8	☐ Month 9	☐ Month 10	☐ Month 11	☐ Month 12	☐ Quarterly	Other:

D. PATIENT INSURANCE INFORMATION

9	Insurance Provider	Name of Insured	Member ID #
10	Secondary Insurance Provider	Name of Insured	Member ID #

E. TRANSPLANT CENTER AND/OR REFERRING LABORATORY INFORMATION

11	Provider Information: Contact Name	Facility Name	Phone
12	Referring Laboratory Information: Contact Name	Facility Name	Phone

F. ADDITIONAL INFORMATION

13	

G. ORDERING PHYSICIAN AUTHORIZATION AND ACKNOWLEDGMENT

Acknowledgment: Your signature constitutes a statement of medical necessity and your attestation that the test was ordered after evaluating its risk/benefit profile, is reasonable and medically necessary, and will be used in the clinical management of the patient. Your signature on this form also indicates that the physician or physician's delegate has obtained all necessary 1) authorizations from the patient to release any medical and insurance information to process claims for services provided by CareDx, Inc., and 2) authorizations to assign the right of the patient to, and authorize payment to CareDx, Inc.

Authorized Ordering Physician Signature:_____ **Date:**_____

CareDx®

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