UPMC LIFE CHANGING MEDICINE

REQUISITION FORM

UPMC Magee-Womens Hospital
UPMC Clinical Genomics Laboratory
300 Halket Street Room 4680
Pittsburgh, PA 15213
GenomicsLab@upmc.edu
Phone (412) 641-2949 | Fax (412) 641-2893

HEREDITARY CANCER PANEL REQUISITION FORM

ROUTE SAMPLE TO UPMC MAGEE-WOMENS HOSPITAL CYTOGENETICS RM 1217 VIA MEDSPEED COURIER FORM MUST BE ENCLOSED WITH SAMPLE AND/OR SECURELY EMAILED TO GenomicsLab@upmc.edu

PATIENT INFORMATION

First name:	**MI:**	**Last name:**
Date of birth:	**Sex:** ☐ M ☐ F	**MRN #:**
Address:		**City:**
State:	**Zip code:**	**Phone:**

Ancestry (check all that apply):

☐ White/Caucasian ☐ Black/African American ☐ Hispanic
☐ Ashkenazi Jewish ☐ Eastern/Central Europe ☐ Middle Eastern
☐ Asian ☐ Western/Northern Europe
☐ Native American ☐ Central/South American ☐ Other:

REFERRING PHYSICIAN INFORMATION

Physician:		
Address:		
City:	**State:**	**Zip Code:**
Phone:	**Fax:**	

NPI#:

Additional Report To:

SPECIMEN INFORMATION

Does this patient have a current or past history of:

☐ Blood transfusion? ☐ Allogenic bone marrow transplant? ☐ Hematologic malignancy?

If the answer is yes to any of these questions, please contact the laboratory to discuss before sending a sample. Peripheral Blood in EDTA (3-5 ml in lavender or pink top tube) preferred. Contact lab before sending other sample types.

STATEMENT OF MEDICAL NECESSITY

By signing, I affirm each of the following:

1. I authorize and direct UPMC Clinical Genomics Laboratory (UCGL) to perform the testing indicated.
2. The testing requested is reasonable and medically necessary, and the test results will impact medical management and treatment decisions for this patient.
3. The patient or legal guardian has been informed of the risks, benefits and limitations of genetic testing and has consented to this test.
4. The person listed as the Ordering Physician is authorized by the law to order the test(s) requested herein.

REQUIRED

Signature of Requesting Physician or Authorized Provider: _____

TEST(S) REQUESTED: Hereditary Cancer Gene Panel (Sunquest Code)

☐ BRCA1 and BRCA2 Rearrangement Analysis **(HCPBRT)**
☐ BRCA1/BRCA2 Comprehensive Analysis **(HCP1)**
☐ Hereditary Breast Cancer Panel **(HCP2)**
☐ Hereditary Breast and Ovarian Cancer Panel **(HCP3)**
☐ Hereditary Colon Cancer and Polyposis Panel **(HCP4)**
☐ Hereditary Cancer Predisposition Panel **(HCP5)**
☐ Hereditary Pancreatic Cancer Panel **(HCP6)**
☐ Hereditary Prostate Cancer Panel **(HCP7)**
☐ Lynch Syndrome Panel **(HCP8)**
☐ Familial Hyperparathyroidism **(HCP9)**
☐ Extended Hereditary Cancer Panel **(HCP10)**
☐ Hereditary Melanoma Panel **(HCP11)**
☐ Hereditary BRCA 1/2 Ashkenazi Founder 3-Site Test **(HCPAJP)**
☐ Reanalysis to: ☐ **HCP2** ☐ **HCP3** ☐ **HCP4** ☐ **HCP5** ☐ **HCP6** ☐ **HCP7** ☐ **HCP10** ☐ **HCP11**

No charge for reanalysis of additional genes within 90 days of initial report.

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INDICATION FOR TESTING

Clinical indication: ☐ Hereditary Breast and Ovarian Cancer (BRCA1/2) ☐ Lynch syndrome/HNPCC (5 gene) ☐ Familial Adenomatous Polyposis (APC) ☐ Treatment planning (systemic therapy for metastatic disease) ☐ OTHER:

Personal History of Cancer: ☐ No ☐ Yes

Cancer type	Check all that apply. Add any other relevant information.	Age at Diagnosis
☐ Breast	☐ Invasive ductal ☐ Invasive lobular ☐ DCIS ☐ Bilateral ☐ Multiple ☐ Metastatic ☐ Triple negative ☐ ≤ 45 years ☐ ≤ 50 years	
☐ Ovary/tubal/peritoneal	☐ Epithelial ☐ Non-epithelial ☐ STIC | Tumor testing: ☐ MSI-H ☐ Abnormal IHC: (describe pattern)	
☐ Endometrial	Tumor testing ☐ MSI-H ☐ Abnormal IHC: (describe pattern)	
☐ Pancreatic	☐ Exocrine ☐ Neuroendocrine	
☐ Prostate	☐ Gleason score ≥ 7 ☐ High/Very High NCCN risk group ☐ Intraductal/cribiform ☐ Metastatic	
☐ Colorectal	☐ Proximal ☐ Distal ☐ Rectal ☐ Multiple ☐ Metastatic Tumor testing ☐ MSI-H ☐ Abnormal IHC: (describe pattern)	
☐ Other cancer(s)		
☐ Polyps	Location: Total adenomas: ☐ 0-10 ☐ 11-20 ☐ >20 Other histology:	

☐ Pathogenic variant identified via tumor sequencing Tumor type: Gene:

☐ Other information

FAMILY HISTORY OF CANCER: ATTACH PEDIGREE OR COMPLETE THE CHART BELOW

Relationship to Patient	Maternal/Paternal	Cancer/ Tumor Site	Age at Diagnosis
	☐M ☐P		
	☐M ☐P		
	☐M ☐P		
	☐M ☐P		

Relative with pathogenic germline variant: ☐ No ☐ Yes **(ATTACH REPORT)** | **GENE:** **Variant:** **Relationship:**

GENES INCLUDED IN EACH PANEL

HCPBRT: BRCA1/2 deletion/duplication
HCP1: BRCA1, BRCA2
HCP2: ATM, BARD1, BRCA1, BRCA2 , CDH1, CHEK2, PALB2, PTEN, RAD51C, RAD51D, TP53, STK11
HCP3: ATM, BARD1, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, DICER1, EPCAM, MLH1, MSH2, MSH6, NF1, PALB2, PMS2, PTEN, RAD51C, RAD51D, STK11, TP53
HCP4: APC, ATM, AXIN2, BMPR1A, CDH1, CHEK2, CTNN1A, EPCAM, GREM1-SCG5, MLH1, MSH2, MSH3, MSH6, MUTYH, NTHL1, PMS2, POLD1, POLE, PTEN, SMAD4, STK11, TP53
HCP5: APC, ATM, AXIN2, BARD1, BMPR1A, BRCA1, BRCA2, BRIP1, CDH1, CDKN2A, CHEK2, CTNN1A, DICER1, EPCAM, GREM1-SCG5, MLH1, MSH2, MSH3, MSH6, MUTYH, NBN, NF1, NTHL1, PALB2, PMS2, POLD1, POLE, PTEN, RAD51C, RAD51D, SMAD4, STK11, TP53
HCP6: APC, ATM, BRCA1, BRCA2, CDKN2A, CHEK2, EPCAM, MLH1, MSH2, MSH6, PALB2, PMS2, STK11, TP53
HCP7: ATM, BRCA1, BRCA2, BRIP1, CHEK2, EPCAM, HOXB13 c.251G>A, MLH1, MSH2, MSH6, PALB2, PMS2, RAD51C, RAD51D, TP53
HCP8: EPCAM, MLH1, MSH2, MSH6, PMS2
HCP9: AP2S1, CASR, CDC73, CDKN1B, GCM2, GNA11, MAX, MEN1, RET
HCP10: AP2S1, APC, ATM, AXIN2, BAP1, BARD1, BMPR1A, BRCA1, BRCA2, BRIP1, CASR, CDC73, CDH1, CDK4, CDKN1B, CDKN2A, CHEK2, CTNNA1, DICER1, EPCAM, FH, FLCN, GCM2, GNA11, GREM1-SCG5, MAX, MEN1, MET, MLH1, MSH2, MSH3, MSH6, MUTYH, NBN, NF1, NTHL1, PALB2, PMS2, POLD1, POLE, POT1, PRKAR1A, PTEN, RAD51C, RAD51D, RB1, RET, SDHA, SDHAF2, SDHB, SDHC, SDHD, SMAD4, STK11, TP53, TSC1, TSC2, VHL
HCP11: BAP1, BRCA2, CDK4, CDKN2A, MITF c.952G>A, POT1, PTEN, RB1, TP53
HCPAJP: BRCA1 c.68_69delAG (aka 185delAG), c.5266dupC (aka 5382insC/5385insC), BRCA2 c.5946del (aka 6174delT)

PAYMENT OPTIONS: EMAIL GENOMICSLAB@UPMC.EDU FOR PRICE ESTIMATES AND AUTHORIZATIONS

☐ **INSURANCE BILLING (copy front and back of insurance card(s) OR complete below)**

Primary Insurance	Insurance ID	Name and DOB of Insured	Patient Relation to Policy Holder
Secondary Insurance	Insurance ID	Name and DOB of Insured	Prior Auth # Prior Auth Date

ICD-10 Code(s) REQUIRED

☐ **INSTITUTIONAL BILLING: CONTACT LAB**

Facility	Contact	Phone	Email

☐ **PATIENT BILL:** I am electing to self-pay. I agree that neither UPMC Clinical Genomics Laboratory nor I will submit a claim to my insurance for this test.