UPMC LIFE CHANGING MEDICINE

Patient Name:_____

Identification Number:_____

HEREDITARY CANCER PANEL REQUISITION FORM

ROUTE SAMPLE TO UPMC MAGEE-WOMENS HOSPITAL CYTOGENETICS RM 1217 VIA MEDPSEED 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)**
☐ Hereditary BRCA 1/2 Ashkenazi Founder 3-Site Test **(HCPAJP)**
☐ Reanalysis to: ☐ **HCP2** ☐ **HCP3** ☐ **HCP4** ☐ **HCP5**

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

UPMC LIFE CHANGING MEDICINE

Patient Name:_____

Identification Number:_____

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: Variant:

☐ 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		
	☐M ☐P		

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

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

☐ **INSTUTIONAL BILLING: CONTACT LAB**

Facility	Contact	Phone	Email

☐ **PATIENT BILL:** I am electing to self-pay. I agree that neither UPMC Clinical Genomics Laboratory or I will submit a clain to my insurance for this test..

GENES INCLUDED IN EACH PANEL

HCPBRT: BRCA1/2 del/dup only

HCPAJP: BRCA1 c.68_69delAG (aka 185delAG), c.5266dupC (aka 5382insC/5385insC), BRCA2 c.5946del (aka 6174delT)

HCP1: BRCA1, BRCA2 sequencing and del/dup

HCP2: ATM, BRCA1, BRCA2 , CDH1, CHEK2, PALB2, PTEN, TP53

HCP3: ATM, BARD1, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, EPCAM, MLH1, MSH2, MSH6, MUTYH, NBN, NF1, PALB2, PMS2, PTEN, RAD51C, RAD51D, STK11, TP53

HCP4: APC, ATM, AXIN2, BMPR1A, CDH1, CHEK2, EPCAM, GREM1, 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, EPCAM, GREM1, 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, NBN, PALB2, PMS2, RAD51C, RAD51D, TP53

HCP8: EPCAM, MLH1, MSH2, MSH6, PMS2