trovagene | trovera

Test Requisition

Phone: 888-391-7992 Fax: 858-952-7665 Email: service@trovagene.com

PATIENT INFORMATION — PLEASE ATTACH PATIENT FACE SHEET

Last Name	First Name	MI	Gender (M/F)

DOB (mm/dd/yy)	Medical Record #	Social Security #

Street Address	City	State	Zip	Phone

Ethnicity (Check all that apply)
☐ Alaskan Native ☐ American Indian ☐ Asian ☐ Pacific Islander ☐ Hispanic/Latino ☐ Black ☐ White ☐ Other___________________________

BILLING INFORMATION — PLEASE PROVIDE COPY OF FRONT & BACK OF INSURANCE CARD OR ATTACH PATIENT FACE SHEET CONTAINING THIS INFORMATION

Bill To ☐ Insurance ☐ Medicare-Part B ☐ Patient ☐ Facility/Hospital/Clinic	Insurance Carrier Name	
Policy Holder Name	Policy #	Group #
Hospital Discharge Date	ICD-10 code(s)	

CLINICAL INFORMATION — PLEASE PROVIDE INITIAL CONSULT & MOST RECENT PROGRESS NOTES, ANATOMIC PATHOLOGY REPORT, MOLECULAR TESTING RESULTS

Treatment Status ☐ New Diagnosis ☐ Recurrence ☐ Progression
☐ Metastasis Location___________________________

	Chemo	Radiation	Immuno	Hormonal	Targeted	Other
Current Therapy	✓					
1st Line						
2nd Line						
3rd Line						

Prior Molecular Testing

Mutation	Results (+/–)	Results Date

Sample Type ☐ Blood ☐ Tissue ☐ Urine

Other Medical Conditions

URINE TEST MENU

CHECK ALL THAT APPLY

☐ EGFR **Quantitative**
(Exon 20 T790M, Exon 19 deletions, and Exon 21 L858R)

EGFR **Quantitative:**
- ☐ **Exon 20 T790M**
- ☐ **Exon 19 deletions**
- ☐ **Exon 21 L858R**

☐ KRAS **Quantitative G12/G13**
☐ BRAF **Qualitative V600E***
*** Histiocytic disorders only**

SPECIMEN INFORMATION

Urine Sample Requirements
100mL urine + preservative in container

Date Collected ____/____/____
Time Collected ____:____ ☐ AM ☐ PM
First Morning Void ☐ Y ☐ N
Preservative Added ☐ Y ☐ N
Specimen Collected ☐ Office ☐ Home

☐ **SEND SPECIMEN COLLECTION KIT TO PATIENT**

BLOOD TEST MENU

CHECK ALL THAT APPLY

☐ EGFR **Quantitative**
(Exon 20 T790M, Exon 19 deletions, and Exon 21 L858R)

EGFR **Quantitative:**
- ☐ **Exon 20 T790M**
- ☐ **Exon 19 deletions**
- ☐ **Exon 21 L858R**

☐ KRAS **Quantitative G12/G13**
☐ BRAF **Quantitative V600E**
(also detects V600K/G/M/R)

SPECIMEN INFORMATION

Blood Sample Requirements
Two 10mL streck tubes

Date Collected ____/____/____
Time Collected ____:____ ☐ AM ☐ PM

The use of Trovagene's urine or blood liquid biopsy is only intended for detection and quantitation of mutations in patient's previously diagnosed with cancer. It is not intended for screening of asymptomatic patients to diagnose cancer.

REASONS FOR SELECTING ctDNA TESTING — CHECK ALL THAT APPLY

Detection ☐ Presence of a mutation ☐ Measure tumor burden (baseline) ☐ Emergence of new mutation(s) ☐ Tissue biopsy unavailable/inconclusive

Monitoring ☐ Treatment response (quantitative) ☐ Minimal residual disease (MRD) ☐ Emergence of resistance mutation(s) ☐ Tissue biopsy unavailable/inconclusive ☐ Provide insight when imaging is unavailable/inconclusive

Other

ORDERING PHYSICIAN INFORMATION

Ordering Physician	NPI #	Physician Email
Account Name	Trovagene Account #	Office Contact
Office Phone	Office Fax	Office Contact Email

Street Address	City	State	Zip

PHYSICIAN/PRACTITIONER SIGNATURE (REQUIRED)

I hereby request and authorize Trovagene, Inc. to utilize the above information to process testing for the indicated patient. I certify that the test is medically necessary and the results will be used in the management of the patient. I certify that I am authorized by law to request the above test and I agree to provide the necessary information and records needed for billing.
Does this patient consent to the use of their sample and data for deidentified research? Consent is implied if a box is not marked. (For patients in N.Y. state, research consent will NOT be implied if left blank.) ☐ **Y** ☐ **N**

Ordering Physician Signature **Date**

Please submit the following
- ☐ Signed Test Requisition Form
- ☐ Face Sheet
- ☐ Billing Information
- ☐ Initial Consult Notes
- ☐ Most Recent Progress Notes
- ☐ Pathology Report
- ☐ Molecular Test Results

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