Variantyx Genomic Unity® Comprehensive Analyses Test Requisition Form

Patient Name | Date of Birth | Affix barcode label of Patient's sample here

Required Information Checklist:

- ☐ Patient demographics
- ☐ ICD-10 codes
- ☐ Healthcare provider signature
- ☐ Signed informed consents
- ☐ Clinical & genetic counseling notes with pedigree (please include all family history of known chronic and inherited disease and copies of genetic test results, if available)
- ☐ Completed TRF and all clinical notes faxed to 617-433-5024
- ☐ Letter of medical necessity and/or required insurance forms if applicable

*Missing or insufficient information will cause a delay in pre-authorization and results.

Clinical Information

ICD-10 Code(s)*	Indication for testing
Suspected Diagnosis	Has this patient received counseling from a board certified genetic counselor? Yes /No
Are the clinical symptoms onset before the age of 21? Yes / No	Is the patient symptomatic? Yes / No
Are there ongoing pregnancies in the family? Yes / No	Has the patient had previous genetic testing? Yes / No *If yes please include copies of the reports.*

Please list previously reported variants here:

Comprehensive Analyses

❍ **Genomic Unity® Whole Genome Analysis (CP001)** ❍ Singleton ❍ Duo ❍ Trio ❍ Expedited (CP100) *This test is available for institutional and patient pay orders only.*

❍ Option to receive Genomic Unity® Pharmacogenomics Analysis (PG001) *No selection will default to opt-out.*
❍ Option to receive ACMG Secondary Findings only *No selection will default to opt-out.*
❍ Option to receive ACMG Secondary Findings with other actionable findings *No selection will default to opt-out.*
❍ If the test above does not yield a diagnostic result, reflex to Genomic Unity® 2.0 (DS001)

❍ **Genomic Unity® Exome Plus Analysis (CP010)** ❍ Singleton ❍ Duo ❍ Trio

❍ Option to receive Genomic Unity® Pharmacogenomics Analysis (PG001) *No selection will default to opt-out.*
❍ Option to receive ACMG Secondary Findings only *No selection will default to opt-out.*
❍ Option to receive ACMG Secondary Findings with other actionable findings *No selection will default to opt-out.*
❍ If the Genomic Unity® Exome Plus Analysis does not yield a diagnostic result, reflex to Genomic Unity® Whole Genome Analysis (CP001).
❍ If the test above does not yield a diagnostic result, reflex to Genomic Unity® 2.0 (DS001).
*This test is applicable for patients with non diagnostic previous exome analysis. *Reflex to CP001 and DS001 might not be covered by insurance.*

❍ **Genomic Unity® Exome Analysis (CP002)** ❍ Singleton ❍ Duo ❍ Trio

❍ Option to receive Genomic Unity® Pharmacogenomics Analysis (PG001) *No selection will default to opt-out.*
❍ Option to receive ACMG Secondary Findings only *No selection will default to opt-out.*
❍ Option to receive ACMG Secondary Findings with other actionable findings *No selection will default to opt-out.*
❍ If the Genomic Unity® Exome Analysis does not yield a diagnostic result, reflex to:
❍ Genomic Unity® Exome Plus Analysis (CP010) ❍ Whole Genome Analysis (CP001)
❍ If the test above does not yield a diagnostic result, reflex to Genomic Unity® 2.0 (DS001).

❍ **Genomic Unity® 2.0 (DS001)** ❍ Singleton ❍ Duo ❍ Trio

❍ Option to receive Genomic Unity® Pharmacogenomics Analysis (PG001) *No selection will default to opt-out.*
❍ Option to receive ACMG Secondary Findings only *No selection will default to opt-out.*
❍ Option to receive ACMG Secondary Findings with other actionable findings *No selection will default to opt-out.*
This test is applicable for patients with non diagnostic previous exome analysis.

❍ **Genomic Unity® Constitutional Genome-Wide Copy Number Variant Analysis (CP004)**

If CP004 does not yield a diagnostic result, select one of the following:
❍ Reflex to Genomic Unity® Exome Analysis (CP002) ❍ Reflex to Genomic Unity® Exome Plus Analysis (CP010)
❍ Singleton ❍ Duo ❍ Trio
If the above reflex option is selected, you may opt to:
❍ Receive ACMG Secondary Findings only *No selection will default to opt-out.*
❍ Receive ACMG Secondary Findings with other actionable findings *No selection will default to opt-out.*
❍ Receive Genomic Unity® Pharmacogenomics Analysis *No selection will default to opt-out.*
❍ If the Genomic Unity® Exome Analysis or Genomic Unity® Exome Plus Analysis does not yield a diagnostic result, reflex to Genomic Unity® Whole Genome Analysis (CP001).
❍ If the test above does not yield a diagnostic result, reflex to Genomic Unity® 2.0 (DS001). *Reflex to CP001 and DS001 might not be covered by insurance.*

Healthcare Provider's Statement

By my signature below, I attest that I am the referring physician, an authorized healthcare provider for the patient or procurator thereof, and this testing is medically necessary for diagnosis and/or treatment of the patient. I attest that the patient or guardian has voluntarily consented to genetic testing for diagnostic purposes, including possible results and outcomes, ACMG secondary findings, and pharmacogenomics analysis, if selected, has been given the opportunity to ask questions about the testing and/or seek genetic counseling, and agrees to allow an independent genetic counselor facilitated through a third party to provide pre-test and/or post-test genetic counseling if required by the insurer and/or referring institution.

Healthcare provider signature _____ Date _____

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Patient Information

First Name	Last Name	MI	DOB	Genetic Sex
				❍ Male ❍ Female ❍ Other _____ Gender identification (optional):
Address		ID / MR#		
City	State	Zip Code	Phone	Email
Other Name (if different than listed above): ❍ Please use this name in communications.			Pronouns	Preffered language ❍ English ❍ Spanish

Comparator Information

First Name	Last Name	DOB	Relationship to proband	Genetic Sex
				❍ Male ❍ Female ❍ Other _____ Gender identification (optional):
If affected by the same disorder as the patient please list the clinical symptoms				
Address			Phone	Email

Comparator Information

First Name	Last Name	DOB	Relationship to proband	Genetic Sex
				❍ Male ❍ Female ❍ Other _____ Gender identification (optional):
If affected by the same disorder as the patient please list the clinical symptoms				
Address			Phone	Email

Ordering Healthcare Provider

First Name	Last Name	Phone	NPI #
Facility Name		Facility Address	City
City	Zip Code	Email	Fax

Additional Report Recipients

Name	Phone	Fax	Email
Name	Phone	Fax	Email

Add GC or other healthcare provider(s)?

Billing Information

❍ Insurance billing	Insurance Company	Policy #	Group #
Policy holder first name	Policy holder Last name	Policy Holder DOB	Who is the Policy Holder? ❍ Patient ❍ Spouse ❍ Parent
Address		Employer's Address	

❍ Institutional billing ❍ Patient Payment *An invoice will be sent to the patient email provided. Insurance will not be billed.*

An invoice will be sent to the institution listed above. Please contact us for alternate billing.

Who should be contacted for billing purposes?
Payer Name: Payer Phone: Payer Email:

Patient Sample Information

Sample Type ❍ Saliva* ❍ Saliva swab*† ❍ Assisted saliva* ❍ Blood ❍ Genomic DNA ❍ Other

*Use Variantyx collection kits only
† Saliva swab may have reduced sensitivity and specificity due to the presence of normal oral flora

Sample Will Be Collected ❍ In-clinic ❍ Patient was given kit ❍ By Variantyx

Please check if your patient has had a: ❍ Blood transfusion within the last two weeks ❍ Bone marrow transplant

We will contact you for additional specimen collection details.

Collection date

*Please note that the newest version of the assay will be selected by default.