siParadigm diagnostic informatics
USA 888-599-5227 / 201-599-9044
201-599-9066
888-890-4774 (Toll-free fax)
PR 888-782-5430
866-369-4114

Requisition Number:
Your Specimen Number
Pick-up Confirmation #

☐ RUSH
☐ Call Results
☐ Need Results by: ___ / ___ / ___

HEMATOPATHOLOGY TEST REQUISITION FORM

For Solid Tumor and Liquid Biopsy testing, kindly complete and return the Solid Tumor and Liquid Biopsy requisition forms.

PATIENT INFORMATION (REQUIRED)

Name Last _____ First _____

Gender ☐ Male ☐ Female Date of Birth ___ (mm) / ___ (dd) / ___ (yyyy)

Street _____

City _____ State _____ ZIP _____

MRN / Patient ID# _____

Phone# _____

For Bone Marrow Transplant Patients Only:
Donor Gender ☐ Male ☐ Female Fill in Mandatory Data at the Back of the Page

PHYSICIAN INFORMATION (REQUIRED)

Referring MD _____

Attending/Ordering MD _____

Account Information _____

SPECIMEN INFORMATION (REQUIRED)

Collection date ___ (mm) / ___ (dd) / ___ (yyyy) Time _____ ☐ AM ☐ PM

Sent date ___ (mm) / ___ (dd) / ___ (yyyy) ☐ Perform CBC in house

☐ CBC results attached (required for Blood and Bone Marrow)

☐ Bone Marrow, [tube(s)] #_____ ☐ Peripheral Blood, [tube(s)] #_____

☐ Fresh Tissue/Fluid, [tube(s)] #_____ ☐ Slide(s): _____

☐ Formalin Container(s) #_____ ☐ Paraffin Block (s) # _____

☐ Other Container(s) # _____ ☐ Other #_____ Specify: _____

BILLING INFORMATION (BOTH SIDES REQUIRED)

☐ Insurance
☐ Client
☐ Patient

SPECIMEN COLLECTION LOCATION
☐ Non-hospital/office patient
☐ Out-patient hospital
☐ In-patient hospital Discharge Date ___ (mm) / ___ (dd) / ___ (yyyy)
☐ Independent ambulatory clinic/surgical center

ICD-10 Code (REQUIRED)

Notes: _____

MOBILE PHLEBOTOMY REQUEST (Oncology Office to Complete if Needed)

Patient Phone (mobile preferred): _____

Patient Email (optional): _____

Patient Home Address: _____

City, ST, ZIP: _____

siParadigm Liquid Biopsy collection and shipping kit was provided to the patient. Please fax this completed requisition, pathology report, and insurance information to 888-890-4774 | By completing this section, Client represents it has obtained patient's consent to be contacted by third-party service.

Attach clinical notes, patient information, CBC, and insurance card (REQUIRED)

LEVEL OF SERVICE (REQUIRED)

☐ **siPortfolio™**
Hematopathologist will select FLOW, IHC, FISH, Karyotype and/or Molecular testing as clinically needed for diagnosis, prognosis and therapeutics.
DO NOT mark any individual test(s)

☐ **Perform Marked Test(s) Only**
Only check if you DO NOT choose siPortfolio

TAT varies according to test(s) chosen. Please see back for details

STAGE OF DISEASE (REQUIRED)

☐ New Diagnosis ☐ Staging Evaluation ☐ Remission ☐ Relapse ☐ Measurable Residual Disease (MRD) ☐ Follow-up/Monitoring

LIST OF DISEASES & FINDINGS

DISEASES

☐ ALL	☐ LPD	☐ MGUS
☐ AML	☐ Lymphoma, Hodgkin	☐ MPN
☐ CLL	☐ Lymphoma, non-Hodgkin	☐ Myeloma (☐MRD)
☐ CML, Follow-up	☐ Marrow infiltration	☐ PNH
☐ CML, New diagnosis	☐ MDS	☐ Other: _____

FINDINGS

☐ Anemia	☐ Leukopenia
☐ Eosinophilia	☐ Lymphadenopathy
☐ Erythrocytosis	☐ Lymphocytosis
☐ Leukocytes, Atypical	☐ Thrombocytopenia
☐ Leukocytosis	☐ Thrombocytosis

DISEASES TO BE RULED OUT

☐ Rule out MDS	☐ Rule out Myeloma
☐ Rule out MPN	☐ Others: _____
☐ Rule out LPD	_____
☐ Rule out Leukemia	

LIST OF INDIVIDUAL TESTS

(See website www.siparadigm.com/compendium/ for detailed panel content)

☐ MORPHOLOGY siPortfolio™

☐ Perform CBC
☐ Peripheral smear review
☐ Bone marrow biopsy and aspirate, including special and immunostains

☐ FLOW CYTOMETRY siPortfolio™

Required: Please specify the level of service
☐ (G) Global ☐ (T) Tech-Only ☐ (P) Professional Only

☐ Leukemia/Lymphoma screen panel with reflex to disease-specific panels
☐ Myeloma (☐MRD)
☐ CLL (☐MRD)
☐ PNH
☐ Other (specify): _____

☐ CYTOGENETICS KARYOTYPE siPortfolio™

☐ Myeloid ☐ T-Lymphoid ☐ B-Lymphoid

☐ CYTOGENETICS FISH siPortfolio™

☐ (G) Global ☐ (T) Tech-Only

☐ ALL	☐ CML	☐ Lymphoma	☐ MZL
☐ AML	☐ DLBCL	☐ Mantle	☐ Waldenström
☐ APL	☐ Eosinophilia	☐ MDS	☐ Other: _____
☐ Burkitt	☐ Follicular	☐ MPN	
☐ CLL	☐ High Grade B-cell	☐ Myeloma	

Specimen Hold Option: ☐ Direct Harvest and Hold (see details at the back)

☐ MOLECULAR siPortfolio™

(See detailed panels content at the back)

☐ Myeloid Focused, DNA
☐ Myeloid Comprehensive, DNA
☐ AML/Eosinophilia, DNA/RNA
☐ Lymphoid

Specimen Hold Options: ☐ Extract and hold DNA/RNA (see details at the back)

Individual Genes (See website under physician tab for a complete list)

*Tests performed by PCR

☐ ABL Kinase Mutation (CML)	☐ BRAF (HCL)*	☐ FLT3 ITD & TKD*	☐ JAK2 Exons 13 & 15*	☐ MYD88 (WM)*	☐ STAT3 and STAT5B (clonal LGL)
☐ B-cell clonality study (IGH)*	☐ CALR*	☐ IDH1/IDH2	☐ JAK2 V617F*	☐ NPM1	☐ TP53
☐ BCR-ABL, Major (CML)*	☐ CSF3R	☐ IGHV hypermutation	☐ KIT D816X*	☐ PML-RARA, Quant	☐ T-cell clonality study (gamma with reflex to beta)
☐ BCR-ABL, Minor (ALL)*	☐ CXCR4 (WM)	☐ JAK2 Exon 12*	☐ MPL*	☐ SF3B1	☐ Other: _____

Reflexes (as clinically indicated)

*Tests performed by PCR

☐ JAK2 V617F* with reflex to:
☐ Polycythemia vera panel (JAK2 exon 12, 13 & 15)
☐ CALR*/MPL* with or without the entire myeloid panel as clinically indicated

☐ Major BCR-ABL Quantitative (p210 M-bcr)* with reflex to:
☐ Minor BCR-ABL Quantitative (p190 m-bcr)*
☐ ABL kinase domain resistance mutations panel

PHYSICIAN SIGNATURE (REQUIRED)

Confirmation of Informed Consent & Statement of Medical Necessity: I affirm each of the following: 1) Testing is medically necessary for the diagnosis of a disease or syndrome. 2) The results will be used in the patient's medical management and treatment decisions. 3) The person listed as the ordering physician is authorized by law to order the test(s) requested herein. 4) I have provided genetic testing information to the patient and the patient has consented to such testing (if applicable).

I am certified to order the test (s) listed above, such that these test (s) are medically necessary and I have obtained informed consent for the requested test (s) when pertinent.

Signature *(MANDATORY FOR TESTING) _____ Date _____

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ADDITIONAL INFORMATION (REQUIRED)

Gender Identity: ☐ Male ☐ Female ☐ Female-to-Male (FTM)/Transgender Male/Trans Man ☐ Male-to-Female (MTF)/Transgender Female/Trans Woman ☐ Genderqueer, neither exclusively male nor female ☐ Additional gender category or other, please specify _____ ☐ Choose not to disclose ☐ Not applicable

Ethnicity: ☐ African-American ☐ Jewish-Ashkenazi ☐ Adopted ☐ Asian ☐ Caucasian/NW European ☐ Jewish-Sephardic ☐ Native American ☐ Hispanic or Latino ☐ Middle Eastern ☐ Unknown ☐ Asked but Unknown ☐ Non-Hispanic or Non-Latino ☐ Other ☐ Choose not to disclose

Sexual Orientation: ☐ Lesbian, gay, or homosexual ☐ Straight or heterosexual ☐ Bisexual ☐ Don't know ☐ Something else, please describe _____ ☐ Choose not to disclose ☐ Not applicable

Race: ☐ American Indian or Alaska Native ☐ Black or African American ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐ Unknown ☐ Asked but Unknown ☐ Other _____ ☐ Choose not to disclose

Billing Information:

Terms and Conditions of Requisition Form

Any organization ("Client") referring specimens for testing services pursuant to this Requisition Form agrees to the following terms and conditions:

1. **Binding Agreement:** This Requisition Form constitutes a contractually binding order for the services and/or tests requested. The Client acknowledges and agrees that it is financially responsible for all tests designated as billable to the Client herein.
2. **Third-Party Billing and Client Financial Responsibility:**
   The Client must accurately indicate on the front of this Requisition Form whether:
   - The Client should be billed directly (e.g., when services are provided under non-fee-for-service models such as capitated agreements, Diagnosis-Related Groups [DRGs], or any bundled or consolidated payment arrangements), **or**
   - The services should be billed to a federal, state, or commercial health insurer, or other third party (collectively referred to as "Payers").

For all services intended to be billed to Payers, the Client agrees to provide complete and accurate billing information necessary for siParadigm to process such claims.

siParadigm reserves the right to bill the Client directly under the following circumstances:

- Required billing information is not provided within ten (10) days of the date the services are reported,
- The patient lacks valid Payer coverage, or
- The Payer denies financial responsibility for the services and indicates that the Client is responsible.

Specimen Requirements:

Specimens should be refrigerated if they are not shipped immediately. During transport, please ensure the use of a cold pack to maintain proper temperature.

For inquiries regarding specimen requirements or shipping instructions within the United States, please contact our Client Services team at **201-599-9044 or 888-599-5227**, or via email at **cs@siparadigm.com**. For clients in Puerto Rico, please contact us at **888-782-5430** or email **cs.pr@siparadigm.com**.

Detailed information on specimen-specific requirements can be found on our website **https://www.siparadigm.com**

For packaging conditions and the required specimen quantity per test, please check our website:

https://www.siparadigm.com/physician-support/specimen-requirements

siParadigm is not responsible for any difference in quantity of specimen if it is not indicated

Specimen Hold Option Descriptions

To preserve the integrity of samples and avoid unnecessary testing, siParadigm Laboratory offers the option of processing samples to maintain specimen integrity for extended periods, without a test order. Specimen Hold Options include:

FISH:Direct Harvest and Hold: Sample should be received at siParadigm Laboratory within 120 hours of collection. Specimens will be minimally processed and directly harvested while the cells are still viable. Analysis is not performed until the client test order is received. Processed samples will be retained for 28 days.

Molecular Testing: Extract Nucleic Acid and Hold: Nucleic acid (DNA or RNA or TNA) will be isolated from viable cells and stored in a freezer. Use this option when it is known which test(s) may be added. Analysis is not performed until the client test order is received. Processed samples will be retained for 28 days.

Add-Ons:

To request add-ons to existing cases, please complete the form on our website/webportal or reach out to our Customer Service team:

- **United States: 201-599-9044 or 888-599-5227, 201-599-9066 | cs@siparadigm.com**
- **Puerto Rico: 888-782-5430, 866-369-4114 | cs.pr@siparadigm.com**
- **The form is available at: www.siparadigm.com/physician-support/physician-requisition-forms**

Pick-Ups:

To arrange a pickup, please contact our Customer Service department:

- **United States: 201-599-9044 or 888-599-5227 | cs@siparadigm.com**
- **Puerto Rico: 888-782-5430 | cs.pr@siparadigm.com**

Detailed Molecular Panels

Myeloid Focused, DNA

ABL1	^IKZF1	SRSF2
^ASXL1	JAK2	^STAG2
^BCOR	KIT	STAT3
BCORL1	KRAS	STAT5B
BRAF	MPL	^TET2
^CALR	MYD88	^TP53
CBL	^NF1	U2AF1
^CEBPA	NOTCH1	WT1
CSF3R	NPM1	^ZRSR2
CXCR4	NRAS	
DDX41	^PHF6	
DNMT3A	PIGA	
^ETV6	PPM1D	
^EZH2	^PRPF8	
FLT3	PTPN11	
GATA1	^RB1	
GATA2	^RUNX1	
HRAS	SETBP1	
IDH1	SF3B1	
IDH2	^SH2B3	

^ indicate full genes (17)

Myeloid Comprehensive, DNA

ABL1	FBXW7	NPM1	STAT3
ANKRD26	FLT3	NRAS	STAT5B
^ASXL1	GATA1	PAX5	^TET2
^BCOR	GATA2	^PHF6	^TP53
BCORL1	GNAS	PIGA	U2AF1
BRAF	GNB1	PPM1D	U2AF2
^CALR	HRAS	^PRPF8	UBA1
CBL	IDH1	PTEN	WT1
CBLB	IDH2	PTPN11	XPO1
CBLC	^IKZF1	^RB1	^ZRSR2
CDKN2A	IL7R	^RUNX1	
^CEBPA	JAK1	SETBP1	
CSF3R	JAK2	SF3A1	
CUX1	JAK3	SF3B1	
CXCR4	KIT	^SH2B3	
DDX41	KRAS	SMARCB1	
DNMT3A	MPL	SMC1A	
ETNK1	MYD88	SMC3	
^ETV6	^NF1	SRSF2	
^EZH2	NOTCH1	^STAG2	

^ indicate full genes (17)

AML/Eosinophilia, DNA/RNA

*ABL1	FLT3	*MYH11	SMC1A
*ALK	*FUS	NF1	SMC3
ANKRD26	GATA2	NPM1	SRSF2
ASXL1	*HMGA2	NRAS	STAG2
*BCL2	HRAS	*NTRK3	*TCF3
BCOR	IDH1	*NUP214	TET2
*BRAF	IDH2	*NUP98	*TFE3
CALR	IKZF1	*PDGFRA	TP53
CBL	*JAK2	*PDGFRB	U2AF1
*CCND1	KIT	PHF6	WT1
CEBPA	*KMT2A	PPM1D	ZRSR2
*CREBBP	(MLL)	PRPF8	
CSF3R	KRAS	PTPN11	
DDX41	*MET	*RARA	
DNMT3A	*MECOM	RB1	
*EGFR	*MLLT10	*RBM15	
*ETV6	*MLLT3	*RUNX1	
EZH2	MPL	SETBP1	
*FGFR1	*MYBL1	SF3B1	
*FGFR2	MYD88	SH2B3	

* Indicates fusion driver genes (30)

Lymphoid

^ATM	GNA13	^SOCS1
B2M	ID3	STAT3
BCL2	^IDH2	STAT5B
^BCL6	^IRF4	STAT6
BIRC3	^KMT2D	^TENT5C
BRAF	MAP2K1	^TET2
BTK	MYC	TNFAIP3
CARD11	MYD88	TNFRSF14
CCND1	NFKBIE	^TP53
^CCND3	NOTCH1	XPO1
CD79B	NOTCH2	
CREBBP	^PAX5	
CXCR4	^PIM1	
DNMT3A	^PLCG2	
EP300	PRDM1	
^EZH2	^PTEN	
ETV6	^RHOA	
FAS	RPS15	
FBXW7	^SAMHD1	
FOXO1	^SF3B1	

^ indicate genes covered full coding sequences (19)