UNITY BY BILLIONTOONE
REQUISITION FORM
UN_TRF_124_2512

1 SELECT TEST PANEL

UNITY Carrier Screen™

☐ **ACOG Guideline Panel**
CFTR • SMN1 • HBB • HBA1 • HBA2

☐ add **Fragile X Syndrome** †
FMR1

☐ add **Plus Panel** †
ACADM • ASPA • DHCR7 • DMD • ELP1 • HEXA • PAH • PMM2

A separate cfDNA fetal risk assay will be run for carrier positive singleton pregnancies. Check here to opt out: ☐

UNITY Aneuploidy Screen™ and 22q11.2 Microdeletion singleton pregnancy

☐ ***chromosomes:***
13 • 18 • 21 • X • Y • 22q11.2

☐ order for twin pregnancy NIPT analysis†
13, 18, 21, and 22q11.2 only. Zygosity included.

OR

UNITY Aneuploidy Screen™ singleton pregnancy

☐ ***chromosomes:***
13 • 18 • 21 • X • Y

☐ order for twin pregnancy NIPT analysis†
13, 18, 21, and 22q11.2 only. Zygosity included.

☐ add **Fetal RhD NIPT** for RhD-negative mothers†

☐ opt out fetal sex†

Add **Fetal Antigen(s) NIPT** for known alloimmunized patients†

Red Blood Cell (RBC) Fetal Antigen
MUST INCLUDE TREATMENT NOTES TO ORDER

☐ C (Big C)	☐ e (little e)	☐ Jkb (Kidd)	☐ N
☐ c (little c)	☐ Fya (Duffy)	☐ K (Kell)	☐ S (Big S)
☐ D	☐ Fyb (Duffy)	☐ k (little k)	☐ s (little s)
☐ E (Big E)	☐ Jka (Kidd)	☐ M	☐ U

Platelet Fetal Antigen ***MUST INCLUDE TREATMENT NOTES TO ORDER***

☐ HPA-1a ☐ Other: _____ (see p2 for the full list of antigens)

† These test options include their respective primary panel (*highlighted teal checkbox*)

2 CLINIC INFORMATION

Clinic Name *

Clinic ID number | Clinic Phone | Clinic Fax

Additional Notes

Ordering Healthcare Provider(s) *

Provider Authorization

By submission of this requisition and accompanying sample, I hereby authorize and direct BillionToOne to (1) utilize the above information to process the indicated test for this patient and (2) release the results and patient information to the patient's third-party payer, as needed. I certify (1) all information provided herein is true and accurate, (2) I am authorized by law to request the test, (3) the test is reasonable and medically necessary for the treatment and management of this patient, (4) the patient has been counseled on the potential results, benefits and limitations of the test, and (5) I have obtained informed consent to the extent required under applicable law. I agree to provide the necessary information and medical records to BillionToOne needed to submit and process claims to payers.

Provider Signature *

MM-DD-YYYY
Date of Authorization

3 CLINICAL INDICATION

Required to select at least one for each test panel.*
The following codes are not exhaustive.

UNITY Carrier Screen *If the patient with singleton pregnancy is found to be a carrier for tested disorders, fetal risk assessment will be performed and O28.5 ICD-10 code will be applied, unless opted out.*

☐ Family history of carrier genetic disease**
Z84.81 **Z84.89**

☐ Testing for genetic disease carrier status
Z31.430 **Z31.440**

☐ Supervision of other normal pregnancy
Z34.81 **Z34.82** **Z34.83**

☐ Family history of intellectual disabilities
Z81.0

☐ Other: _____

UNITY Aneuploidy Screen
Code determined by trimester of pregnancy.

☐ Supervision of elderly primigravida
O09.511 **O09.512** **O09.513**

☐ Supervision of elderly multigravida
O09.521 **O09.522** **O09.523**

☐ Supervision of other high risk pregnancies
O09.891 **O09.892** **O09.893**

☐ Supervision other normal pregnancy
Z34.81 **Z34.82** **Z34.83**

☐ Abnormal ultrasound findings
O28.3

☐ Abnormal chromosomal & genetic findings
O28.5

☐ Other: _____

UNITY Fetal RhD/Fetal Antigen
Code determined by trimester of pregnancy.

☐ Maternal care for anti-D [Rh] antibodies
O36.0110 **O36.0120** **O36.0130**

☐ Encounter for Rh incompatibility status
Z31.82

☐ Maternal care for other isoimmunization
O36.1910 **O36.1920** **O36.1930**

☐ Other: _____

**ICD-10 code selected under one test panel might be used in other test panels' billing.*
***Requires Additional Code*

4 CLINICAL BACKGROUND

Pregnancy Details *Select if applicable*

☐ twins ☐ triplets or more ☐ vanishing twin

☐ egg donor/gestational carrier age of egg donor

Abnormal Ultrasound Findings

Ethnicity or Race
ICD-10 code Z15.89 will be applied for high risk ethnicities.

☐ African/African American ☐ Ashkenazi Jewish
☐ Asian ☐ French Canadian/Cajun ☐ Hispanic
☐ Middle Eastern ☐ White ☐ other ☐ unknown

Link to Reproductive Partner (if applicable)
Include first, last name, and DOB

☐ Maternal ☐ Paternal

Reported Carrier History
Include condition and variant when possible

☐ Known Maternal Carrier

☐ Known Paternal Carrier

5 SAMPLE COLLECTION DATE & BARCODE

MM-DD-YYYY

PLACE PROVIDED BARCODE HERE

6 PATIENT INFORMATION

The information in this section may also be provided as an attachment. Incomplete info may delay test processing.

First Name * | MI

Last Name *

Sex assigned at birth * | Maternal Weight (lbs)

Date of Birth * (MM-DD-YYYY) | Estimated Due Date * (MM-DD-YYYY)

☐ not pregnant

By providing the information below, I agree I or my provider may be contacted for test status, billing/collection, marketing, quality assurance, or research purposes.

Email | Cell Phone *

Street Address | Apt / Unit / Suite

City | State | Zip Code

Patient Acknowledgement

I acknowledge I have read and agreed to the Patient Acknowledgement for testing on the back page.

Patient Signature | Date (MM-DD-YYYY)

7 BILLING INFORMATION

☐ **Bill to Insurance** ☐ **Bill to Patient** ☐ **Bill to Client**

Insurance Company Name

Member ID | Group ID

☐ Ordering provider or facility is out-of-network with the patient's insurance plan

Attach copy of insurance card

UNITY Complete®

(UNITY Carrier Screen + UNITY Aneuploidy Screen)

UNITY Carrier Screen: *cfDNA fetal risk assessment for recessive conditions can be performed at ≥9 weeks gestation, can only be performed for singleton pregnancies, and cannot be performed for egg donors or gestational carriers. *Carrier screening for X-linked conditions is not performed for male patients, and cfDNA fetal risk assessment is provided via fetal sex, unless fetal-sex has been opted out.* ***UNITY Aneuploidy:*** *can be performed at ≥9 weeks gestation. Sex chromosome aneuploidies can only be performed for singleton pregnancies.*

3 × 10 mL Streck cell-free DNA BCT® blood tube

Fill to the top (≥ 8mL)

UNITY Carrier Screen

Recessive Conditions Screened

cfDNA fetal risk assessment will be provided for positive carrier test results unless opted out

ACOG Guideline Panel

- **Cystic Fibrosis** *CFTR*
- **Hemoglobinopathies (Sickle Cell Disease, Alpha / Beta Thalassemias)** *HBA1, HBA2, HBB*
- **Spinal Muscular Atrophy** *SMN1*

Fragile X Syndrome *FMR1**

Plus Panel

- **Canavan Disease** *ASPA*
- **DMD-Associated Dystrophinopathies** *DMD**
- **Familial Dysautonomia** *ELP1*
- **Medium-Chain Acyl-CoA Dehydrogenase Deficiency** *ACADM*
- **Phenylalanine Hydroxylase Deficiency** *PAH*
- **PMM2-Congenital Disorder of Glycosylation** *PMM2*
- **Smith-Lemli-Opitz Syndrome** *DHCR7*
- **Tay Sachs Disease** *HEXA*

1 × 10 mL Streck cell-free DNA BCT® blood tube

Fill to the top (≥ 8mL)

UNITY Aneuploidy Screen

Chromosomal Conditions Screened and Optional Testing

- **Down Syndrome** *T21*
- **Edwards Syndrome** *T18*
- **Patau Syndrome** *T13*
- **Sex Chromosome Aneuploidies** *Monosomy X, XXY, XXX, XYY*
- **Zygosity** (included for twin pregnancies)
- **Optional: Fetal Sex**
- **Optional: 22q11.2 Microdeletion Syndrome**
- **Optional: Fetal RhD** for RhD-negative Pregnant Patients
- **Optional: Red Blood Cell Fetal Antigen**
  Supporting clinical documentation is required for order
  Big C, little c, D, E, e, Fya(Duffy), Fyb (Duffy), Jka (Kidd), Jkb (Kidd), K(Kell), k, M, N, Big S, little s, U
- **Optional: Platelet Fetal Antigen**
  Supporting clinical documentation is required for order
  *HPA-1a (with HLA-DRB3*01:01 when applicable) HPA-1b, HPA-2a, HPA-2b, HPA-3a, HPA-3b, HPA-4a, HPA-4b, HPA-5a, HPA-5b, HPA-9a, HPA-9b, HPA-15a, HPA-15b*

2 × 10 mL Streck cell-free DNA BCT® blood tube

Fill to the top (≥ 8mL)

ICD-10 DIAGNOSIS CODES *Codes are not exhaustive, provide additional codes as necessary.*

UNITY Carrier Screen

Female for testing for genetic disease carrier status for procreative management	**Z31.430**
Male for testing for genetic disease carrier status for procreative management	**Z31.440**
Supervision of normal first pregnancy, unspecified trimester	**Z34.00**
Supervision of normal first pregnancy, first trimester	**Z34.01**
Supervision of normal first pregnancy, second trimester	**Z34.02**
Supervision of other normal pregnancy, unspecified trimester	**Z34.80**
Supervision of other normal pregnancy, first trimester	**Z34.81**
Supervision of other normal pregnancy, second trimester	**Z34.82**
Supervision of normal pregnancy, unspecified, first trimester	**Z34.91**
Family history of intellectual disabilities	**Z81.0**
Family history of carrier genetic disease	**Z84.81**
Family history of other specified conditions	**Z84.89**

UNITY Aneuploidy Screen

Supervision of elderly primigravida, first trimester	**O09.511**
Supervision of elderly primigravida, second trimester	**O09.512**
Supervision of elderly multigravida, first trimester	**O09.521**
Supervision of elderly multigravida, second trimester	**O09.522**
Supervision of other high risk pregnancies, first trimester	**O09.891**
Supervision of other high risk pregnancies, second trimester	**O09.892**
Abnormal ultrasonic finding on antenatal screening of mother	**O28.3**
Abnormal chromosomal and genetic finding on antenatal screening of mother	**O28.5**
Maternal care for (suspected) chromosomal abnormality in fetus	**O35.1XX0**
Maternal care for (suspected) chromosomal abnormality in fetus 1	**O35.1XX1**
Encounter for Rh incompatibility status	**Z31.82**
Encounter for antenatal screening for chromosomal anomalies	**Z36.0**
Family history of chromosomal abnormalities	**Z82.79**

PATIENT ACKNOWLEDGEMENT

I have been informed of and understand the details of the tests ordered herein for me by my healthcare provider, including the risks, benefits and alternatives, and consented to testing. I understand (1) the test results may inform me of a medical condition that may require follow-up and (2) a negative result does not rule out the possibility of such medical condition in the fetus, myself or my partner. I hereby authorize (1) the release to BillionToOne of any medical and insurance information necessary to process claims and recover reimbursement for services provided by BillionToOne and (2) BillionToOne to pursue all necessary appeals of any denials of payment in relation to services provided by BillionToOne. I understand that the test may not be (1) covered by my insurer/health plan, or (2) deemed medically necessary and I am responsible for any costs not paid by my plan directly to BillionToOne, including any copayments, deductibles or amounts deemed 'patient responsibility'. I acknowledge that I may be responsible for non-covered services. BillionToOne may (1) contact my healthcare provider to obtain more information regarding clinical correlation and confirmatory testing and (2) contact my provider or me for test status, billing/collection, marketing, quality assurance or research purposes.

BEFORE YOU SHIP, please ensure that:

- ☑ **Test panel** and **ICD10 codes** are selected
- ☑ **Required fields** on this form are completed
- ☑ **Insurance card copies** are included (front and back)
- ☑ **Provided barcode** is affixed to tubes and this form
- ☑ Requisition is **signed**

Call **1-800-463-3339 (1-800-GO FEDEX)** to schedule a pickup