

1 SELECT TEST PANEL

Samples without a test panel selected will not be processed.



REQUISITION FORM
UN\_TRF.085\_2605

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.

add Fetal RhD NIPT for RhD-negative mothers†
opt out fetal sex†

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

UNITY Aneuploidy Screen™ singleton pregnancy

chromosomes: 13 • 18 • 21 • X • Y

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

2 SAMPLE COLLECTION DATE & BARCODE

MM-DD-YYYY

PLACE PROVIDED BARCODE HERE

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

Ordering Healthcare Provider(s) \*

Empty box for ordering healthcare provider information.

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.

MM-DD-YYYY

Provider Signature \*

Date of Authorization

5 CLINIC INFORMATION

Clinic Name \*

Clinic Phone

Clinic Fax

Clinic Account Number

Additional Notes

4 PATIENT INFORMATION

First Name \* MI Last Name \*
lbs MM-DD-YYYY MM-DD-YYYY

Sex assigned Maternal Weight Date of Birth \* Estimated Due Date \*
at birth \* 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.

Cell Phone \* Email

Street Address Apt / Unit / Suite

City State Zip Code

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.

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

Reported Carrier History Include condition and variant when possible

- Known Maternal Carrier
Known Paternal Carrier

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

- Maternal Paternal

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

MM-DD-YYYY

Patient Signature

Date of Acknowledgement

6 BILLING INFORMATION

- Bill to Insurance Bill to Patient Bill to Client

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

Attach copy of insurance card

Insurance Company Name

Member ID

Group ID

TEST PANEL	TEST DETAILS	SAMPLE REQUIREMENT
<b>UNITY Complete®</b>	<b>UNITY Carrier Screen + UNITY Aneuploidy Screen</b> See conditions below	<b>3 ×</b> 10 mL Streck cell-free DNA BCT® blood tube <b>Fill to the top (≥ 8mL)</b>
<b>UNITY Carrier Screen</b> <i>Recessive Conditions Screened</i>  <i>cfDNA fetal risk assessment will be provided for positive carrier test results unless opted out</i>	<b>ACOG Guideline Panel</b> <ul style="list-style-type: none"> <li>Cystic Fibrosis <i>CFTR</i></li> <li>Hemoglobinopathies (Sickle Cell Disease, Alpha / Beta Thalassemias) <i>HBA1, HBA2, HBB</i></li> <li>Spinal Muscular Atrophy <i>SMN1</i></li> </ul> <b>Fragile X Syndrome <i>FMR1*</i></b>  <b>Plus Panel</b> <ul style="list-style-type: none"> <li>Canavan Disease <i>ASPA</i></li> <li>DMD-Associated Dystrophinopathies <i>DMD*</i></li> <li>Familial Dysautonomia <i>ELP1</i></li> <li>Medium-Chain Acyl-CoA Dehydrogenase Deficiency <i>ACADM</i></li> <li>Phenylalanine Hydroxylase Deficiency <i>PAH</i></li> <li>PMM2-Congenital Disorder of Glycosylation <i>PMM2</i></li> <li>Smith-Lemli-Opitz Syndrome <i>DHCR7</i></li> <li>Tay Sachs Disease <i>HEXA</i></li> </ul>	<b>1 ×</b> 10 mL Streck cell-free DNA BCT® blood tube <b>Fill to the top (≥ 8mL)</b>
<b>UNITY Aneuploidy Screen</b> <i>Chromosomal Conditions Screened</i>	<ul style="list-style-type: none"> <li>Down Syndrome <i>T21</i></li> <li>Edwards Syndrome <i>T18</i></li> <li>Patau Syndrome <i>T13</i></li> <li>Sex Chromosome Aneuploidies <i>Monosomy X, XXY, XXX, XYY</i></li> <li>Zygosity for Twin Pregnancies</li> <li>Optional: Fetal Sex</li> <li>Optional: Fetal RhD for RhD-negative Pregnant Patients</li> <li>Optional: 22q11.2 Microdeletion Syndrome</li> </ul>	<b>2 ×</b> 10 mL Streck cell-free DNA BCT® blood tube <b>Fill to the top (≥ 8mL)</b>

**UNITY Fetal Risk 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.

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

UNITY Carrier Screen		UNITY Aneuploidy Screen	
Female for testing for genetic disease carrier status for procreative management	<b>Z31.430</b>	Supervision of elderly primigravida, first trimester	<b>O09.511</b>
Male for testing for genetic disease carrier status for procreative management	<b>Z31.440</b>	Supervision of elderly primigravida, second trimester	<b>O09.512</b>
Supervision of normal first pregnancy, unspecified trimester	<b>Z34.00</b>	Supervision of elderly multigravida, first trimester	<b>O09.521</b>
Supervision of normal first pregnancy, first trimester	<b>Z34.01</b>	Supervision of elderly multigravida, second trimester	<b>O09.522</b>
Supervision of normal first pregnancy, second trimester	<b>Z34.02</b>	Supervision of other high risk pregnancies, first trimester	<b>O09.891</b>
Supervision of other normal pregnancy, unspecified trimester	<b>Z34.80</b>	Supervision of other high risk pregnancies, second trimester	<b>O09.892</b>
Supervision of other normal pregnancy, first trimester	<b>Z34.81</b>	Abnormal ultrasonic finding on antenatal screening of mother	<b>O28.3</b>
Supervision of other normal pregnancy, second trimester	<b>Z34.82</b>	Abnormal chromosomal and genetic finding on antenatal screening of mother	<b>O28.5</b>
Supervision of normal pregnancy, unspecified, first trimester	<b>Z34.91</b>	Maternal care for (suspected) chromosomal abnormality in fetus	<b>O35.1XX0</b>
Family history of intellectual disabilities	<b>Z81.0</b>	Maternal care for (suspected) chromosomal abnormality in fetus 1	<b>O35.1XX1</b>
Family history of carrier genetic disease	<b>Z84.81</b>	Encounter for Rh incompatibility status	<b>Z31.82</b>
Family history of other specified conditions	<b>Z84.89</b>	Encounter for antenatal screening for chromosomal anomalies	<b>Z36.0</b>
		Family history of chromosomal abnormalities	<b>Z82.79</b>

**PATIENT ACKNOWLEDGEMENT** Read and sign the front page.

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, quality assurance or research purposes.

**BEFORE YOU SHIP, please ensure that:**

<input checked="" type="checkbox"/> <b>Test panel and ICD10 codes</b> are selected	<input checked="" type="checkbox"/> <b>Required fields</b> on this form are completed	<input checked="" type="checkbox"/> <b>Insurance card copies</b> are included (front and back)	<input checked="" type="checkbox"/> <b>Provided barcode</b> is affixed to tubes and this form	<input checked="" type="checkbox"/> <b>Requisition is signed</b>
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Call 1-800-463-3339 (1-800-GO FEDEX) to schedule a pickup