Decision Dx SCC

Customer service: **866-788-9007**
Fax toll free: **866-329-2224**
Alternate fax: **602-266-9597**
Email: **clinicalservices@castlebiosciences.com**

I. Ordering entity information

Provider name*	NPI	Institution / Practice name*	
Address*	City / state / zip*		Specialty
Office contact name*	Phone*	Fax*	Email

II. Patient information

Name (last, first, MI)*	DOB*	Gender	SSN / MR#
Address*	City / state / zip*		
Phone*	Email		

III. Billing information

Submitting diagnosis / ICD-10 code*
Please select code from dropdown list

Payment method ☐ Private insurance ☐ Patient self-pay ☐ Medicare ☐ Medicaid ☐ Client bill *(contracted entities only)*

Insurance name*	Policy #*	Insurance phone	Secondary insurance? ☐ Yes ☐ No *(If yes, attach copy of card)*

IV. Facility information* *(Required for all patients)*

At time of tissue collection, was this patient: ☐ Non-hospital ☐ Hospital outpatient ☐ Hospital inpatient If hospital inpatient, discharge date: _____

If specimen is stored **for more than 30 days** from the date of collection, please provide the date specimen is pulled from archive: _____

V. Clinical information* This product is validated for patients with one or more high-risk features. Please check all that apply from both columns.

REQUIRED SECTION
MISSING RESPONSES WILL DELAY TEST PROCESSING

History and Physical Exam:

Is the patient immunocompromised due to solid organ transplant, lymphoma/leukemia, or HIV? ☐ Yes ☐ No

Is the tumor located on the head or neck? ☐ Yes ☐ No

What is the tumor's diameter? ☐ <2 cm ☐ 2 to <4cm ☐ ≥4 cm

Surgical and Pathological Findings:

Is there perineural involvement (any size)? ☐ Yes ☐ No

Is it poorly differentiated? ☐ Yes ☐ No

CHECK ANY ADDITIONAL HIGH RISK FEATURES:

History and Physical Exam:

- ☐ Tumor location on the hands, genitals, feet or pretibial surface (areas H or M)
- ☐ Rapidly growing tumor
- ☐ Tumor with poorly defined borders
- ☐ Tumor at site of prior radiation therapy or chronic inflammation
- ☐ Neurologic symptoms in region of tumor

Surgical and Pathological Findings

- ☐ Depth *(Invasive beyond subcutaneous fat or Invasion beyond 2mm or Clark Level IV)*
- ☐ Aggressive histologic subtype[A]
- ☐ Lymphovascular invasion
- ☐ Desmoplastic SCC

[A]Acantholytic (adenoid), adenosquamous (showing mucin production), or carcinosarcomatous (metaplastic) subtypes (others will be considered on a case-by-case basis)

VI. Required signature*

This signature confirms that the test is medically necessary for this patient. This clinician provides consultation and/or treatment for squamous cell carcinoma and will use results in the management of the patient. This clinician further acknowledges that any information derived from Castle Biosciences testing will not be used for research or test development without providing prior written notice to Castle Biosciences and receiving written acknowledgment in response. Any unauthorized use may be prohibited by applicable laws and regulations, including those implemented by the U.S. Food and Drug Administration.

Signature of treating clinician*	Printed name*	Date*

VII. Treating clinician

Provider name *(if different than section I)*	Phone	Fax	Institution / Practice name
Address (☐ same as requestor)	City / state / zip		

VIII. Laboratory contact information

Facility where tissue is maintained	☐ Mohs debulk in formalin	Collection date*
Phone	Fax	

INTERNAL USE ONLY

In addition to this test requisition form, please provide a copy of the path report from the primary biopsy and the Mohs debulk (if available).

* Required item

DecisionDx-SCC

SECTION I. Complete with information of the ordering entity.

SECTION II. Complete with patient information.

SECTION III. Provide the ICD-10 code and patient's diagnosis. Select method of payment. Please complete with billing information including a copy of the front and back of the insurance card (if applicable). If the person completing this requisition is not in possession of the information necessary for completion of the billing information section, please provide the name/department and contact information of the appropriate party from whom this information can be obtained.

Name: _____ Department: _____
Phone: _____ Fax: _____

**If a copy of the front and back of the insurance card is provided, no further information is needed in this section of the requisition. A billing face sheet is also sufficient in lieu of copy of card.*

SECTION IV. Complete information for the patient. This is required for all patients.

SECTION V. Please select all required clinical features on the left, which are required for processing, then select any additional features present on the right. This test is validated for patients with squamous cell carcinoma tumors which have at least one high risk feature. This/these feature(s) can be either clinical in nature, or pathology derived, or both.
Note: DecisionDx-SCC has not been evaluated for testing in tissue from locally recurrent tumors.

SECTION VI. The ordering clinician must sign this section. **Note:** For purposes of ordering this test, the "ordering clinician" section can be signed only by a physician, advanced practice registered nurse (APRN) or representative physician associate (PA).

SECTION VII. Complete with information for the treating clinician, if applicable. If the mailing address is the same as for the ordering clinician, check the box "same as requestor".

SECTION VIII. Complete this section with the name and contact information for the facility from which the tissue block(s) or slides for testing can be requested.

Contact customer service: **866-788-9007**
Fax the following documents toll free: **866-329-2224**
or email **reqs@castlebiosciences.com** (Alternate fax: **602-266-9597**).

Required to submit a complete order

- ☐ Completed requisition
- ☐ Pathology report(s)
- ☐ Mohs report (if available)

If you are interested in online ordering, please contact us at
clinicalservices@castlebiosciences.com

***Note:** Order confirmation will be sent to the ordering clinician via fax within 24 hours of receipt*

CASTLE BIOSCIENCES
3737 N 7th Street, Suite 160
Phoenix, AZ 85014
castlebiosciences.com
100 S. Commons, Suite 245
Pittsburgh, PA 15212