MyPath Melanoma®

Diagnostic GEP to aid in the characterization of primary cutaneous lesions with uncertain malignant potential.

Customer service: **866-788-9007**
Fax toll free: **866-329-2224**
Email: **clinicalservices@castlebiosciences.com**

I. Ordering entity information

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

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* D48.5 Neoplasm of uncertain behavior of skin	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. Additional 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*

I attest the specimen being submitted for testing is a primary cutaneous melanocytic neoplasm for which the diagnosis is uncertain, (despite the performance of standard-of-care test procedures and relevant ancillary tests), the patient may be subjected to additional intervention as a result of the diagnostic uncertainty, and this patient was not receiving immunosuppressant or radiation therapy at the time of biopsy.

☐ Yes ☐ No

VI. Required signature

This signature confirms the test to be medically necessary for this patient. This clinician provides consultation and/or treatment for cutaneous melanoma 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 ordering provider*	Printed name*	Date*

VII. Treating clinician information

Treating clinician name	Phone	Fax	Institution / Practice name
Address (☐ same as requestor)	City / state / zip		

VIII. Laboratory and specimen information

Please submit a pathology report along with this test requisition form. If a pathology report is unavailable, please complete all fields in the following section.

Tumor site	Specimen ID*	Collection date*
Facility where tissue is maintained	Name of pathologist	
Phone	Fax	

INTERNAL USE ONLY

* Required item

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. Required for all patients.

SECTION V. Check the appropriate box confirming unknown malignant potential.

SECTION VI. The treating clinician must sign this section. ***For purposes of ordering this test, the "treating clinician" section can be signed only by a physician, advanced practice registered nurse (APRN), or representative Physician Assistant (PA)*** Please check the box if you would like access to online ordering.

SECTION VII. Complete with information for the treating clinician and/or clinicians. If the mailing address is the same as for the treating clinician, check the box "same as requestor".

SECTION VIII. Complete this section with the name of the facility where the tissue from which the slides for testing will be requested. Provide the name and phone number of an individual to whom a tissue request should be made.

Contact customer service: **866-788-9007**
Fax the following documents toll free: **866-329-2224**
or email **reqs@castlebiosciences.com** (Alternate fax: **602-222-5200**).
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*

☐ Completed requisition
☐ Pathology report(s)

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