AdvanceAD Tx™

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

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* ☐ L20.81 Atopic neurodermatitis ☐ L20.82 Flexural eczema ☐ L20.84 Intrinsic (allergic) eczema ☐ L20.89 Other specified atopic dermatitis

Payment method ☐ Private insurance ☐ Patient self-pay ☐ Medicare ☐ Medicaid Secondary insurance? ☐ Yes ☐ No *(If yes, attach copy of card)*

Insurance name	Policy #*	Insurance phone

Parent/Guardian name* (if patient is a minor, please provide)

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: _____

V. Specimen information*

Is this patient currently being considered for FDA-approved systemic therapy to treat atopic dermatitis, and do you intend to use the results of this molecular test to help inform therapy selection?*
☐ Yes ☐ No

Please collect two skin samples from the most severe lesion, 2 cm apart. If multiple sites are equally severe, prioritize sampling in the following order: arms/wrists, trunk, legs, head/neck. If the hands, feet, or scalp contain the most severe lesion, these sites may be used for the first sample only. The second sample should be collected from the arms/wrists, trunk, legs, or head/neck. Please see the reverse side for more details.

Site A location*	Site B location*
Collection date*	

VI. Required signature

This signature confirms the test to be medically necessary for this patient. This clinician provides consultation and/or treatment for atopic dermatitis 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*

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. Complete information for the patient.

SECTION V. Identify two areas for skin scraping from the most severe lesion. When possible, collect both samples from the same lesion at least 2 cm apart.

- If multiple lesions are equally severe, prioritize sampling in the following order: arms/wrists, trunk, legs, head/neck, hands, feet, scalp.
- If the hands, feet, or scalp contain the most severe lesion, these sites may be used for the first sample only. The second sample should be collected from the arms/wrists, trunk, legs or head/neck.
- Ideally, select a lesion that has not received topical treatment within the past two weeks.
- Do not include genital samples.
- Do not sample an infected lesion.
- Do not include bloodied samples.

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 assistant (PA).

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 DOCUMENTS:

☐ Completed requisition
☐ Signed clinic notes (document supporting atopic dermatitis diagnosis)

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

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