CASTLE BIOSCIENCES

DecisionDx-UM DecisionDx-PRAME DecisionDx-UMSeq

8667 E. Hartford Drive
Scottsdale, Arizona 85255
Customer Service:866-788-9007

Fax completed form to: 866-329-2224
Alternative Fax: 602-266-9597

Requisition Form

I. Ordering Entity Information

Name of Ordering Physician, PA, NP*

Specialty NPI

Address*

City / State / Zip*

( ) ( )
Telephone* Fax*

Institution / Practice Name*

II. Patient Information

Last Name* First Name* MI

DOB* Gender* SSN / MR#*

Address*

City / State / Zip*

( )
Telephone*

Email

III. Billing Information

Submitting Diagnosis* ICD-10 Code*

Method of Payment:

☐ Private Insurance ☐ Patient Self-Pay
☐ Medicare ***Section V required*** ☐ Medicaid
☐ Client Bill *(contracted entities only)*

Primary Insurance Co. Name Policy#

( )
Insurance Co. Phone#

Secondary Insurance? ☐ Yes ☐ No
(If yes, attach copy of front/back of secondary insurance card)

IV. Test Menu (REQUIRED)

Primary Test: ☐ DecisionDx-UM Gene Expression Profile
Add-On Test: ☐ DecisionDx-PRAME

Additional Testing: (check box, if desired) ☐ DecisionDx-UM***Seq*** Sequencing Test *(GNAQ, GNA11, CYSLTR2, PLCB4, EIF1AX, SF3B1,BAP1)*

V. Additional Information *(REQUIRED for all patients)*

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

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

VI. Clinical Information (REQUIRED)

Has the tissue in this sample been exposed to radiation? ☐ No ☐ Yes

VII. Required Signature

X

SIGNATURE OF TREATING CLINICIAN*

Printed Name

Date

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

VIII. Treating Clinician

Name of Treating Clinician *(if different than section I)*

( ) ( )
Phone # Fax#

Mailing Address (☐ same as requestor)

City / State / Zip

Institution/Practice Name

Email address for report notification

Additional Clinician *(optional)*

( ) ( )
Phone # Fax#

Mailing Address (☐ same as requestor)

City / State / Zip

Institution/Practice Name

Email address for report notification

INTERNAL USE ONLY

IX. Sample Collection Facility

Type of Specimen being submitted for testing: ☐ Fine Needle Aspiration Biopsy ☐ Slides from Formalin Fixed Paraffin Embedded Tumor Tissue

Name of Facility where tissue is maintained: *Date of Collection:

Facility Contact Person: Phone: Fax:

* Required item

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Requisition Form

Requisition Form Completion Instructions

The nature of frozen specimens requires close coordination between the treating clinician and our laboratory. Therefore, if you are a new customer, we request that you call our customer service line (866-788-9007, option 1) and email Clinical Services (clinicalservices@castlebiosciences.com) so we can coordinate the process prior to placement of an order.

1. **Section I**: Complete with information of the ordering clinician.
2. **Section II**: Complete with patient information
   *A patient social security number OR medical record number **must** be provided.
3. **Section III**: Provide the patient's diagnosis and 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: _____
4. **Section IV**: Select the desired test by checking the appropriate box. One can order Gene Expression Profile alone or with add-on tests DecisionDx-PRAME and/or DecisonDx-UMSeq NGS.
5. **Section V**: Required for all patients.
6. **Section VI**: This section is **required.** Check the appropriate box to indicate whether the current sample has been exposed to radiation.
7. **Section VII:** The treating clinician must sign this section. **For purposes of ordering this test, the "treating clinician" section can be signed only by a clinician, advanced practice registered nurse (APRN) or representative Physician Assistant (PA)**.
8. **Section VIII:** Complete with information for the treating clinician (if different from Section I). If the mailing address is the same as for the ordering clinician, check the box "same as requestor". Be sure to select the preferred method by which results should be communicated and provide an email address to receive electronic notification that the report is available.
   If you would like to have Castle Biosciences provide results to a collaborating clinician, please provide that clinician's information in the area marked "ADD'L Clinician" and a copy of the report will be provided to that individual.
9. **Section IX:** This section is **required**. Complete with the type of specimen being submitted for testing, the name of the facility where the procedure is performed and the specimen collection date.

FAX THE FOLLOWING DOCUMENTS TOLL FREE AT
1-866-329-2224 (Alternate fax: 602-266-9597)

- ☐ Completed requisition
- ☐ Pathology report *(for FFPE specimens only)*
- ☐ Signed letter of medical necessity

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