HeartCare® | AlloMap® HEART | AlloSure® HEART

PLACE ALLOSURE ACCESSION LABEL HERE

PLACE ALLOMAP ACCESSION LABEL HERE

HeartCare for Heart Transplant Test Requisition Form

If you need help finding a blood draw center for HeartCare, call 1-888-255-6627.

DRAW SITE NAME		
DRAW DATE	COLLECTION TIME ○am ○pm	PHELEBO INITIALS
IN FREEZER TIME (ALLOMAP ONLY) ○am ○pm		ALLOMAP PROCESSOR INITIALS

All items in red required. Missing information may delay testing

Ordering Physician: Complete sections A, B, C, D, E, F, G (for additional comments) and H.
Phlebotomists: Complete red boxes, right, with draw site, draw date, collection time and your initials.
Lab: Affix first accession label from tube and accession labels card in top right corner, as indicated.

Numbered rows 1-11 and 13 contain fields that MUST be completed. MISSING INFORMATION MAY DELAY TESTING.

A. TEST BEING ORDERED

1 ☐ HeartCare (2 tests: AlloMap and AlloSure) ☐ AlloMap alone ☐ AlloSure alone

B. PATIENT AND PRESCRIBER INFORMATION

2	Patient Last Name		Patient First Name	MI ☐ n/a	Unique Patient Identifier (e.g., MRN)
3	DOB (mm/dd/yyyy)	Biological Sex: ☐ Male ☐ Female	Is this patient a multi-organ recipient? ☐ No ☐ Yes (STOP-Test is not intended for multi-organ transplant recipients. Please contact Customer Care to discuss options.)		Patient's Primary Phone
4	Patient's Address		City	State / Zip	Patient's Email
5	Ordering Physician		NPI		

C. CLINICAL INFORMATION

6 Transplant Date (mm/dd/yyyy) | ICD-10 code: ☐ T86.39 - Other complications of heart-lung transplant ☐ Z94.1 - Heart Transplant Status ☐ Z48.21 - Encounter for aftercare following heart transplant ☐ Other:_____

7 Reason for Ordering Test (choose one):
☐ SURVEILLANCE testing in lieu of a surveillance (protocol) biopsy, consistent with the protocol and practice of the center at which the patient is enrolled.
☐ FOR-CAUSE testing ordered **in lieu of biopsy**, OR **to further inform on the need for a biopsy**, OR **to further inform on the results of a biopsy**. No biopsy was performed concurrent with the test or within the prior week.
☐ OTHER. Reason for test:_____

8 **CHOOSE ONE**: ☐ Deceased related donor (complete row 9 below) (for AlloSure only) ☐ Deceased unrelated donor | ☐ **HOSPITAL DRAW ONLY:** Check if this is an inpatient, if testing order is <14 days from inpatient discharge, and/or if patient coverage is under private insurance case rate. In such cases, the hospital may be billed for the test.

9 **CHOOSE ONE** (for AlloSure only): Donor Relationship — If related donor, please select the relationship of donor to recipient.
☐ Parent ☐ Child ☐ Grandparent ☐ Grandchild ☐ Sibling ☐ Half-sibling ☐ Fraternal twin ☐ Aunt ☐ Identical twin (STOP-Test not intended for Identical Twin)
☐ Great aunt ☐ Great uncle ☐ Niece ☐ Nephew ☐ Great niece ☐ Great nephew ☐ Cousin ☐ Uncle ☐ Other (specify):_____

D. ORDER FREQUENCY

10 **Check appropriate order schedule (choose one). Order may not exceed 12 months.**
☐ Single Order
☐ Heart Allograft Routine Testing Schedule post-transplant; Year 1: Months 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12; Years 2&3: Quarterly; Years 4+: Biannually
☐ Custom Order (complete section below):
For changes to the above, after submission of this order, please call CareDx at 1-888-255-6627 or email at CustomerCare@CareDx.com.

Start Date (mm/dd/yyyy)

☐ Month 0	☐ Month 1	☐ Month 2	☐ Month 3	☐ Month 4	☐ Month 5	☐ Month 6	☐ Month 7	☐ Month 8	☐ Month 9	☐ Month 10	☐ Month 11	☐ Month 12	☐ Quarterly	Other:

E. PATIENT INSURANCE INFORMATION

11	Insurance Provider	Name of Insured	Member ID #
12	Secondary Insurance Provider	Name of Insured	Member ID #

F. TRANSPLANT CENTER AND/OR REFERRING LABORATORY INFORMATION

13	Provider Information: Contact Name	Facility Name	Phone
14	Referring Laboratory Information: Contact Name	Facility Name	Phone

G. ADDITIONAL INFORMATION

15 _____

H. ORDERING PHYSICIAN AUTHORIZATION AND ACKNOWLEDGMENT

Your signature constitutes a Statement of Medical Necessity (SOMN) and your attestation of the following: (1) Accurate clinical information has been entered above. (2) The patient meets the test criteria. (3) I have evaluated the risk/benefit profile of the test and the test is medically necessary and test results will be used with other clinical data to assess the probability of allograft injury, rejection or otherwise to inform clinical decision making and to aid in guiding treatment decisions for the patient. (4) The patient has consented for this test to be performed and for CareDx to release test information for treatment, care coordination, and/or when necessary to obtain reimbursement or payment. (5) Physician or physician's delegate has the authorization to sign support forms and documents on behalf of the ordering physician for CareDx Orders (electronic, PA signature requirements). **Acknowledgment:** Your signature on this form indicates that the physician or physician's delegate has obtained all requisite authorizations from the patient necessary to authorize the release of any medical and insurance information necessary to process claims for services provided by CareDx, Inc., and has obtained all requisite authorizations to assign the right of the patient to, and authorize payment to CareDx, Inc. for all services provided by CareDx, Inc. CareDx, Inc. is authorized to pursue all necessary appeals of full or partial payment on behalf of the patient with his or her health insurance company in relation to services provided by CareDx, Inc. In exchange for this assignment of benefits, CareDx, Inc. agrees to accept assignment from the patient's health insurance company as payment in full.

Authorized Ordering Physician Signature:_____ **Date:**_____

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