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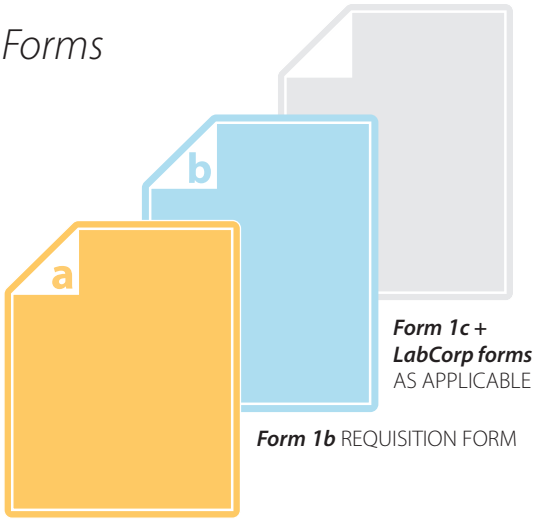
Uveal Melanoma

Prognostic Genetic Test Submission Guide

1 Forms

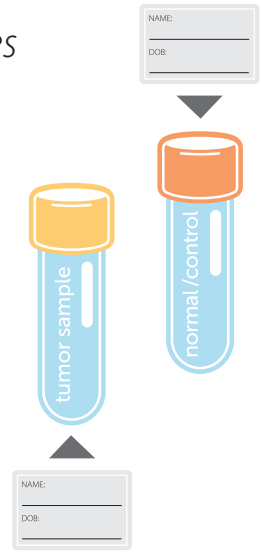


Form 1c + ***LabCorp forms*** AS APPLICABLE

Form 1b REQUISITION FORM

Form 1a INFORMED CONSENT

2 Samples



3 Ship

Impact Genetics
1100 Bennett Road - Unit 4
Bowmanville, ON LIC 3K5
1-877-624-9769

Results

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Form 1a: *Informed Consent to Perform Genetic Testing for Uveal Melanoma*

The purpose of my DNA test is to look for mutation(s) or genetic alterations known to be associated with prognosis for survival in patients with uveal melanoma. I understand this test requires tumor and blood (or other normal) samples for use in prognostic testing.

By signing below, I acknowledge that:

1. My participation in this DNA testing is voluntary. The decision to consent to, or to refuse the above testing is entirely mine.
2. This testing is done on small biological samples.
3. It is possible that the quantity or quality of sample submitted may be inadequate for testing.
4. I understand that prognostic genetic tests for uveal melanoma are not entirely predictive. Patients with a good prognosis can develop metastatic disease (albeit rarely) and vice versa.
5. Impact Genetics will disclose the test results ONLY to the specialist designated on the Requisition Form (***Form 1b***), or to his/her agent, unless otherwise authorized by the patient or required by law, except as described in point 9 below, no information will be printed or released that discloses the patient's identity, or other confidential information.
6. Impact Genetics is not a DNA banking facility and patient DNA samples may not be available for future testing.
7. There is a chance that the test may reveal unexpected abnormalities that may be of medical value in the patient's care. Impact Genetics will inform the referring specialist designated below.
8. Until the results of this test are reported, the patient should still undergo examinations as prescribed by the referring specialist.
9. If necessary to obtain reimbursement of test fees, Impact Genetics, its agents and legal representatives may disclose information that identifies the patient or other confidential information (including test results).
10. I have read or have had read to me, the above information and I understand it. I have also read or had explained to me the specific disease or condition tested for, and the specific test(s) I am having, including the test descriptions, principles and limitations. I have had the opportunity to discuss the purposes and possible risks of this testing with my doctor or someone my doctor has designated.

Consent for Future Research:

After all analysis required to reach a genetic diagnosis is complete, Impact Genetics has my consent to use any surplus DNA in an **anonymous** fashion for research.

☐ YES ☐ NO

Signature of Patient: _____ Date: _____

Signature of Witness: _____ Date: _____

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LAB USE ONLY DO NOT FILL OUT

Date received: Y M D

Specimen type:

Condition:

MRN: Tech:

Form 1b: *Uveal Melanoma Prognostic Genetic Test Requisition*

Ordering Options

☐ Uveal Melanoma Prognostic Genetic Test

▸ *For BAP 1 Germline Analysis -Complete a BAP1 Test Requisition*

Patient

Last name:

First name:

Date of birth: Y M D

Gender: ☐ Male ☐ Female

Ethnicity:

Pigmentation:

Skin color: Hair color:

Eye color:

Specimen Information

Tumor collection method:

☐ FNAB ☐ Enucleation ☐ Surgical resection

☐ Other:

Tumor sample (required):

☐ Fresh tumor in cell lysis (Impact Genetics collection tube)

☐ Frozen tumor ☐ To follow (sending separately)

☐ DNA from tumor ☐ Other:

Date of collection: Y M D

Time of collection: HH:MM (24hr)

Normal/control sample (required):

☐ Buccal swab (UM Prognostic Test only)

☐ Blood (UM Prognostic Test and *BAP1* Germline Analysis)

Date of collection: Y M D

Time of collection: HH:MM (24hr)

Histology

Tumor thickness* (by ultrasound, mm):

Largest basal tumor diameter** (LBD, mm):

Anatomic sub-classification:

☐ Choroid ☐ Iris ☐ Ciliary body involvement

☐ Other:

Extraocular extension (spread) present: ☐ Yes ☐ No

Mitotic count: per HPF

Closed loops: ☐ Yes ☐ No

Predominant cellular classification:

☐ Pure spindle ☐ Predominantly spindle ☐ Epitheloid

☐ Predominantly epitheloid ☐ Unknown

Necrosis: ☐ Yes ☐ No

AJCC TNM stage:

** *These values are required for TNM survivorship prediction.*

Patient History

Diagnosis date: Y M D

Type of primary management:

☐ None ☐ Proton beam radiotherapy ☐ Enucleation

☐ Plaque therapy ☐ Other:

Date: Y M D

Referring Specialist

Name:

Specialty:

Contact:

Telephone: Fax:

Email:

Signature:

Institution:

Address:

City: Prov/State:

Postal code: Country:

Additional copies to:

Email: Fax:

Billing

Impact Genetics tests ordered through LabCorp test menu.
USA only.

☐ a) Client Bill

Provide details:

☐ b) Patient Pay

Complete ***LabCorp Financial Responsibility Form****.*

☐ c) Third party insurance (USA only)

Complete ***Form 1c:*** *U.S. Insurance Information and to expedite testing, complete* ***LabCorp Financial Responsibility Form****.*

Ordering Specialist: By submitting this form, I confirm that this test is being ordered for the purpose of prognosis as per the **Laboratory and Specimen Collection Centre Licensing Act** (Ontario, Canada).

1100 Bennett Road - Unit 4, Bowmanville, ON L1C 3K5
t: 647-478-4902 or 1-877-624-9769 f: 905-697-9786
e: info@impactgenetics.com *Please ensure to use secure email*

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Form 1c: *U.S. Insurance Information*

Impact Genetics is committed to providing the highest quality genetic testing to all patients. In many situations, genetic testing improves outcomes and quality of life and decreases total costs to the patient and healthcare system.

Processing medical insurance claims is usually challenging and time consuming. Many insurance companies require pre-authorization prior to testing. Impact Genetics supports insurance billing, completing coverage checks and pre-authorization.

It is important for patients to understand that insurance rarely covers 100% of the cost of genetic testing and that they will be financially responsible for some or all of the cost of testing. The patient is responsible for any portion of the test fee not covered by insurance for any reason, including but not limited to, co-payments, unmet deductibles, co-insurance and non-covered services. Prior determinations do not guarantee payment and the amount paid by insurance when the claim is submitted may be different from the coverage indicated during the pre-verification or pre-authorization process.

Pre-authorizations can take time to obtain depending on each individual insurance plan's policy and documentation requirements. Turnaround time for test results begins after the pre-authorization has been processed and approved.

For tests ordered through LabCorp, LabCorp administers billing. The LabCorp prior-authorization team will file a pre-verification/prior-authorization on behalf of the patient with any commercial insurance company. State managed Medicare plans cannot be billed.

Insurance process

1. Send ***Form 1c:*** *U.S. Insurance Information* as soon as possible.
2. Send ***LabCorp Financial Responsibility Form*** to initiate testing immediately.
3. Insurance coverage will be investigated and patient/specialist will be contacted to provide coverage estimate.
4. Insurance claim will be submitted upon completion of testing.
5. After insurance payment is received patient will be billed for non-covered services.

Note: Timely and complete submissions will enable faster insurance checks.

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Send this form to LabCorp
BY FAX TO 1-888-598-7568

Form 1c: *U.S. Insurance Information - Uveal Melanoma*

Disease /Genetic Test

☐ Test # 480344 - Uveal melanoma

ICD-10 Code •• *provide code here* ••▸ _____

CPT Codes: 81294, 81403, 81406, 81479, 81301

Insurance Information

☐ Primary insurance ☐ Secondary insurance

If Patient has secondary insurance, include the information on an additional copy of this form with the secondary insurance box checked.

Name of insured (if not Patient):

_____

Insurance company: _____

Claims address: _____

_____

City: _____

State: _____ Zip code: _____

Country: _____

Group #: _____

Subscriber/member #: _____

Physician Information

Physician's name: _____

NPI: _____

Practice name: _____

Practice Address: _____

_____

Telephone: _____

Fax: _____

LabCorp account #: _____

Testing process will be initiated when
LabCorp Financial Responsibility Form *is received or confirmation is received from insurance provider.*

Patient Information

Last name: _____

First name: _____

Date of birth: Y _____ M _____ D _____

Address: _____

_____

City: _____

State: _____ Zip code: _____

Country: _____

Telephone: _____

Contact Information

Details of insurance coverage will be communicated. Please provide preferred telephone number(s):

☐ Patient ☐ Referring specialist

Telephone: _____

Alternate telephone: _____

Email: _____

☐ *In the event Patient cannot be reached a voice message related to uveal melanoma genetic testing may be left at the above phone number(s)*

Please Attach <u>All</u> of the Following

- Copies of both the front and back of insurance membership card(s)
- Letter of Medical Necessity, signed by Referring Specialist (contact Impact Genetics for template if needed)
- Clinic notes demonstrating the Patient's need for testing and confirmation of diagnosis
- Insurance approval details ***if*** prior pre-approval completed

Performing Lab - Impact Genetics
1100 Bennett Road - Unit 4
Bowmanville, ON L1C 3K5 CANADA
t: 1-877-998-7837 f: 1-888-598-7568
e: preverification@labcorp.com *<u>Please ensure to use secure email</u>*

LabCorp **Statement of Financial Responsibility**

Section A: Member/Patient Information

Member/patient name: _____ / Date of birth: _____

Address: _____

City: _____ / ST: _____ / ZIP: _____

Specimen #: _____ / Client account #: _____ / Client phone #: _____

Subscriber #: _____

Section B: Requested procedure or service information

Based on information given to us by your insurance plan, your plan is **not expected to pay 100%** for the laboratory test(s) ordered by your physician/healthcare provider (marked below).

Test/CPT Description	Reason for Patient Out of Pocket	Estimated Cost*

Total Estimated Patient Responsibility*: _____

*This is only an estimate. Actual amount owed may be adjusted based on final coverage amount.

Next Steps:

- Read this notice and decide if you agree to be financially responsible for the estimated patient responsibility costs listed above.
- Choose an option below about whether to receive the items listed in Section B above.
- Sign below and return this form to us within 5 calendar days via email, fax, or mail to the addresses listed below. We will not proceed until we receive this signed consent form with an option checked.

Section C: Options — Check only one box. We cannot choose a box for you.

Option 1 — **I want** the laboratory test(s) marked above to be performed. I understand that my insurance plan is not expected to pay for these test(s) at 100% and I agree to be personally and fully responsible for payment.

I would like to set up a payment plan for $_____a month.**

Option 2 — **I want** the services listed above, but **do not** bill my insurance. I understand I cannot appeal the coverage of these services with my insurance plan if they are not billed. Discounts may apply to the services listed above. Payment in full is required in order to proceed with the testing services.

Option 3 — **I do not want** the laboratory test(s) marked above to be performed. I understand with this choice I am not responsible for payment. No test will be performed and my plan will not be billed.

Patient can contact the Billing department at 888-210-9264 to discuss payment options. For non-billing questions, call 855-488-8750.

**Your first invoice will include the full balance due. If your payment plan is approved, you will receive another invoice that reflects your requested payment amount.

Signature: _____ / Date: _____

Please print name: _____

LabCorp

www.LabCorp.com

Email this form to: / **Fax this form to:**

Mail this form to: LabCorp Prior Authorization
PO Box 2230 / Millstream Mailstop 285 / Burlington NC 27216-2230

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Step 2: *Uveal Melanoma Prognostic Genetic Test Sample Requirements*

U.S. insurance patients: a completed ***Form 1c****: U.S. Insurance Information* must be provided.

Kit includes:

- One tube with cell lysis for tumor sample
- One tube with cell lysis for buccal swab sample
- One sterile cytology brush for buccal swab collection
- Plastic bag to place samples in
- Absorbent pad for shipping
- Rigid box for shipping
- Patient lables

Samples required (both required):

- **Normal sample:** buccal swab or blood sample
- **Tumor sample:** tumor biopsy (FNAB or other)

Sample Preparation Instructions

Normal sample:

- **Blood samples for DNA:** 10 mls venous blood in yellow-topped ACD tubes or lavender-topped EDTA tubes at room temperature, to be received within 5 days after draw.

Or

- **Buccal swab:**
  - Do a gentle mouth rinse with water to clear the mouth of debris.
  - Scrape the inside of the patient's mouth using ten strokes with the collection brush (provided). Either cheek is fine.
  - Eject the tip by firmly pressing the plunger at the end of the handle into the provided tube labelled **Buccal** (provided).
- Label the tube with one of the stickers (provided), complete with the patient name and date of birth.
- Once the buccal sample is in the tube, seal tube with twist top cap, it can be stored at room temperature or refridgerated (4˚C or 39˚F) until shipping.
- Place the tube in the plastic bag and rigid container (provided).

Tumor sample:

- **FNAB**: Place the FNAB sample in the collection tube (provided). Two or more FNAB passes are preferred and all passes can be combined in one tube.

Or

- **Biopsy**: If possible, larger tumor tissue samples from a biopsy are preferred. Place the fresh tumor sample in the collection tube (provided). **DO NOT FIX** the tissue.
- Label the tube with one of the stickers (provided), complete with the patient name and date of birth.
- Once the tumor sample is in the tube, seal tube with twist top cap. Tube can be regridgerated stored (4˚C or 39˚F) until shipping.
- Place the tube in the plastic bag and rigid container (provided). Leave the absorbent pad in the plastic bag

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Step 3: *Shipping Requirements*

Multiple separated samples may be shipped in one box. Place multiple biohazard bags containing labeled samples into one box. Multiple boxes can be shipped in one courier envelope.

Shipping Instructions

- Ship samples to Impact Genetics at address shown on this page using a courier envelope.
- Include Uveal Melanoma Informed Consent and Requisition Forms (***1a*** and ***1b)*** with the samples. Patients in the U.S. must also include U.S. Insurance Information (***Form 1c***) if required and not provided previously.
- Complete appropriate Air Waybill. If you cannot use FedEx or Purolator, please contact us.
- Place Air Waybill in the document pouch.
- For samples from outside of Canada, complete and sign appropriate customs forms (provided and available on our website; phone us if help is required). Place the customs forms in the document pouch.
- Within Canada, use **Purolator Express** (next-day) or **FedEx Priority** service (next-day). Outside of Canada use **FedEx Priority** service (next-day) and **use a FedEx "Clinical Pak"**. If you cannot use Purolator or FedEx, please contact us.
- Provide us with the parcel tracking number soon after courier pick-up: **647-478-4902, info@impactgenetics.com**.
- For emailed PDF FedEx waybills and customs forms, please contact us directly.

Send to Impact Genetics

mail: Impact Genetics
1100 Bennett Road - Unit 4
Bowmanville, ON L1C 3K5

tel: 1-877-624-9769

fax: 905-697-9786