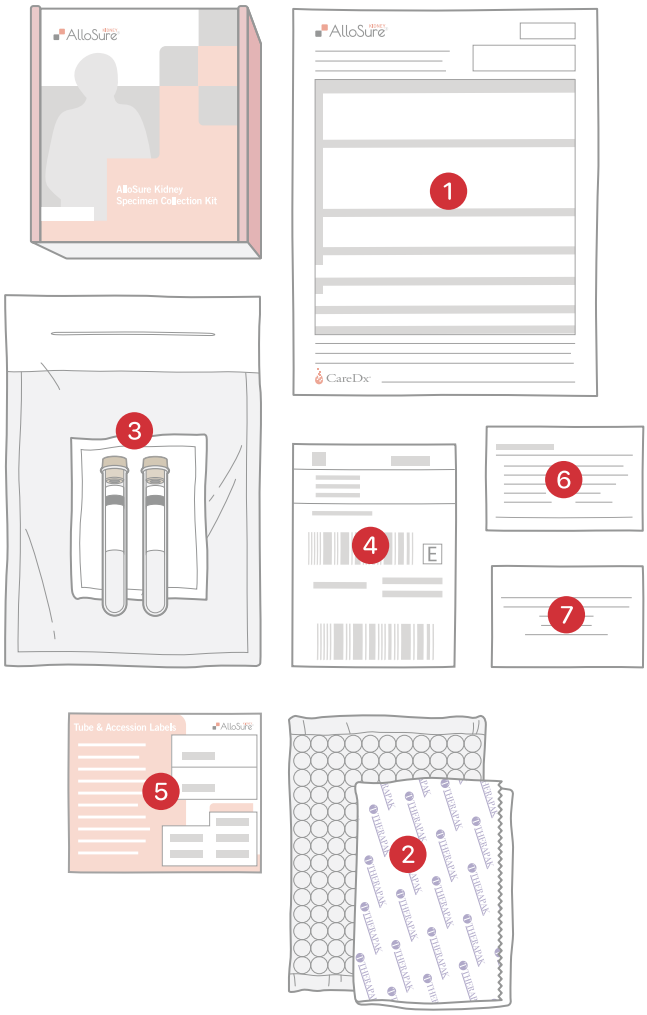
CareDx®

AlloSure Draws

Kidney and Lung

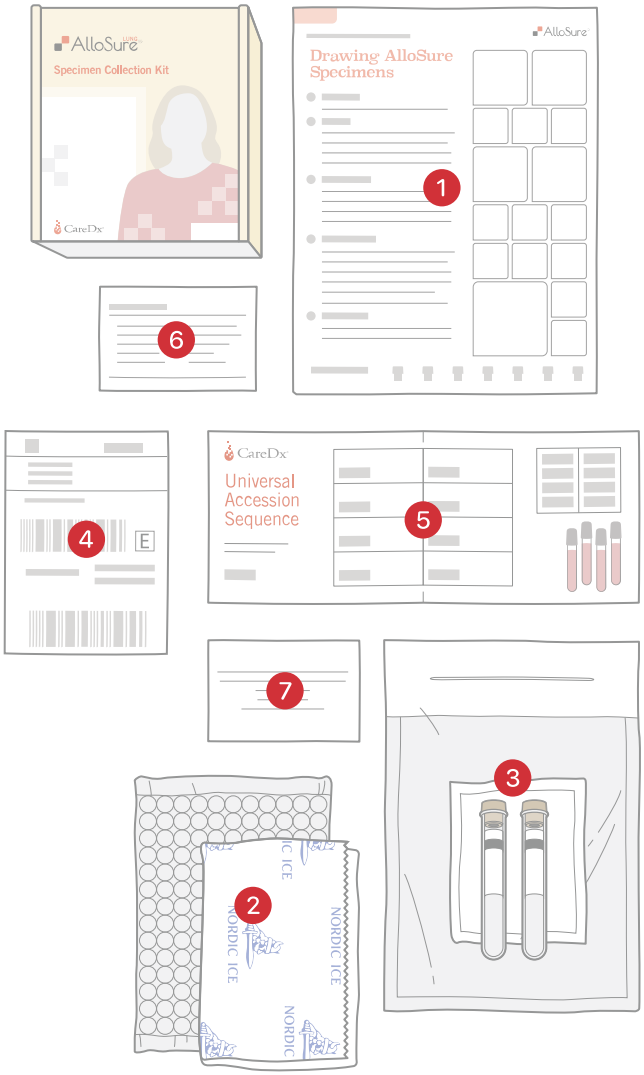
Your kit may look different than what is pictured here

AlloSure Kit Contents



Therapak

1. **T**est **R**equisition **F**orm
2. Foil pack/gel pack/specimen bag
3. 2 Streck tubes in absorbent pouch inside specimen bag
4. Shipping bag / shipping label
5. Label card for tubes
6. List of Contents card
7. Streck tube card (optional)

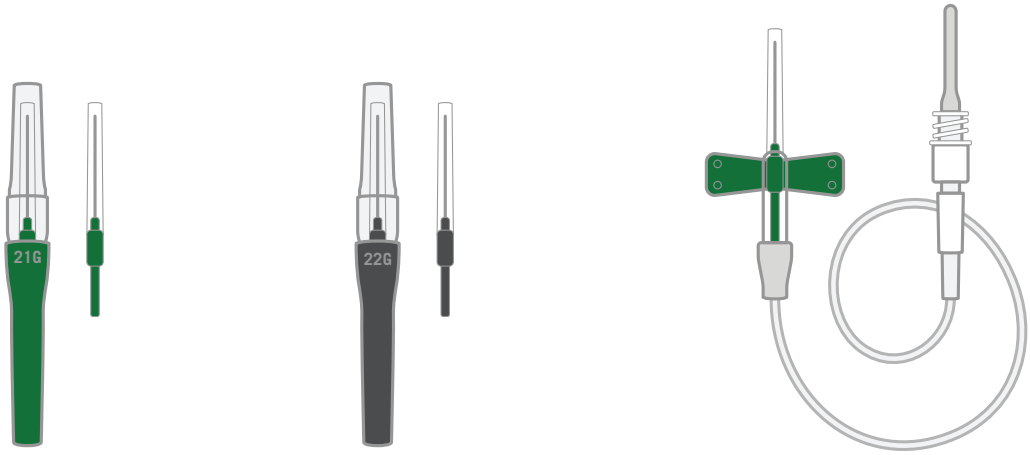


BioTouch

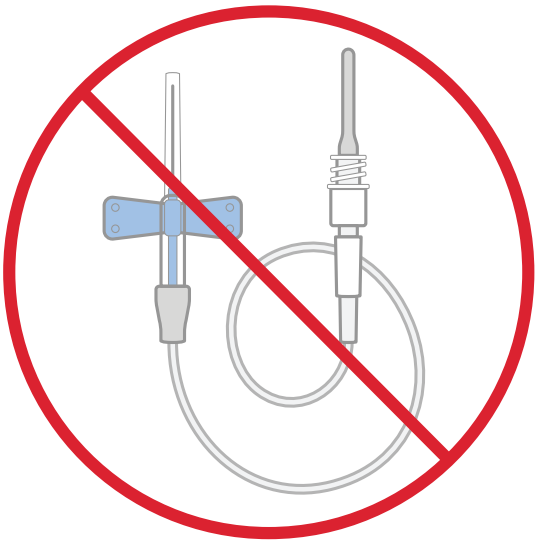
1. Quick Draw Instructions
2. Foil pack/gel pack/specimen bag
3. 2 Streck tubes in absorbent pouch inside specimen bag
4. Shipping bag / shipping label
5. Label card for tubes
6. List of Contents card
7. Streck tube card (optional)

Correct Needle Sizes for AlloSure Collections

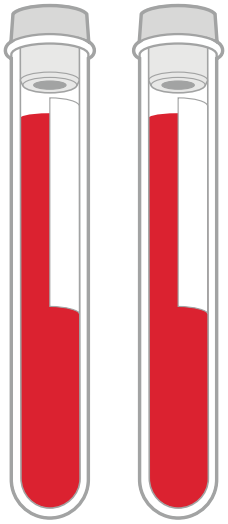
Utilizing the correct needle size will help to eliminate hemolysis issues. The pressure put on the cells by the small bore size of the needle and the vacuum from the tube can crush the blood cells.



Use no smaller than a 22 gauge needle when drawing AlloSure specimens.

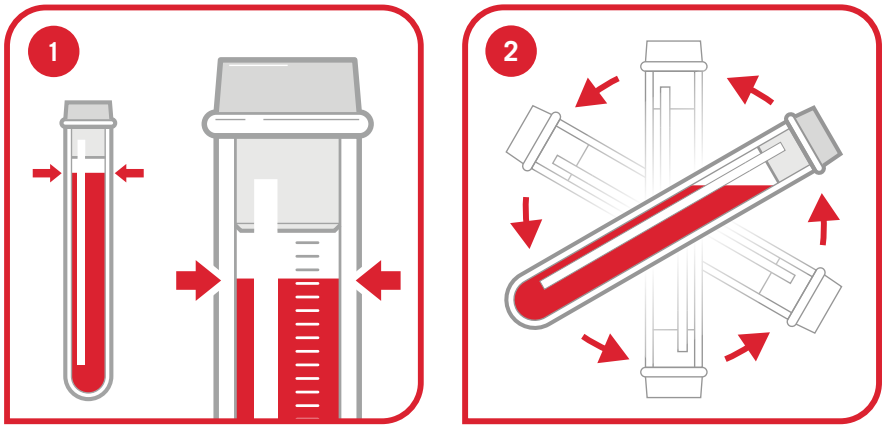


Draw Instructions



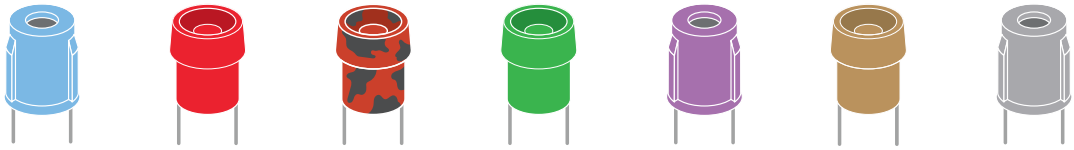
1. Draw two 8 ml glass Streck tubes.
   - ONE Streck tube needs to be completely full. Fill the 2nd tube as much as possible
   - For smaller pediatric patients only 5-6mL, or half of one tube, is needed.
2. Invert all tubes 8-10 times after draw.

ALLOSURE TUBES ARE NOT TO GO THROUGH THE PNEUMATIC TUBE SYSTEM



Draw Order

This is the draw order to be followed for AlloSure testing.



1	2	3	4	5	6	7
Sodium Citrate	Serum	SST	Heparin	EDTA	Streck	Fluoride Oxalate

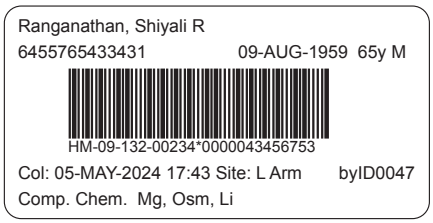
Labeling Instructions

CareDx Labels:

- Use the labels in the kit for labeling
- Do not use GEL pens – use ball point or a fine point Sharpie
- You MUST complete all the highlighted areas
  - Patient name (as on order)
  - Patient DOB
  - Draw Date
  - Phlebotomist Initials

Hospital Labels:

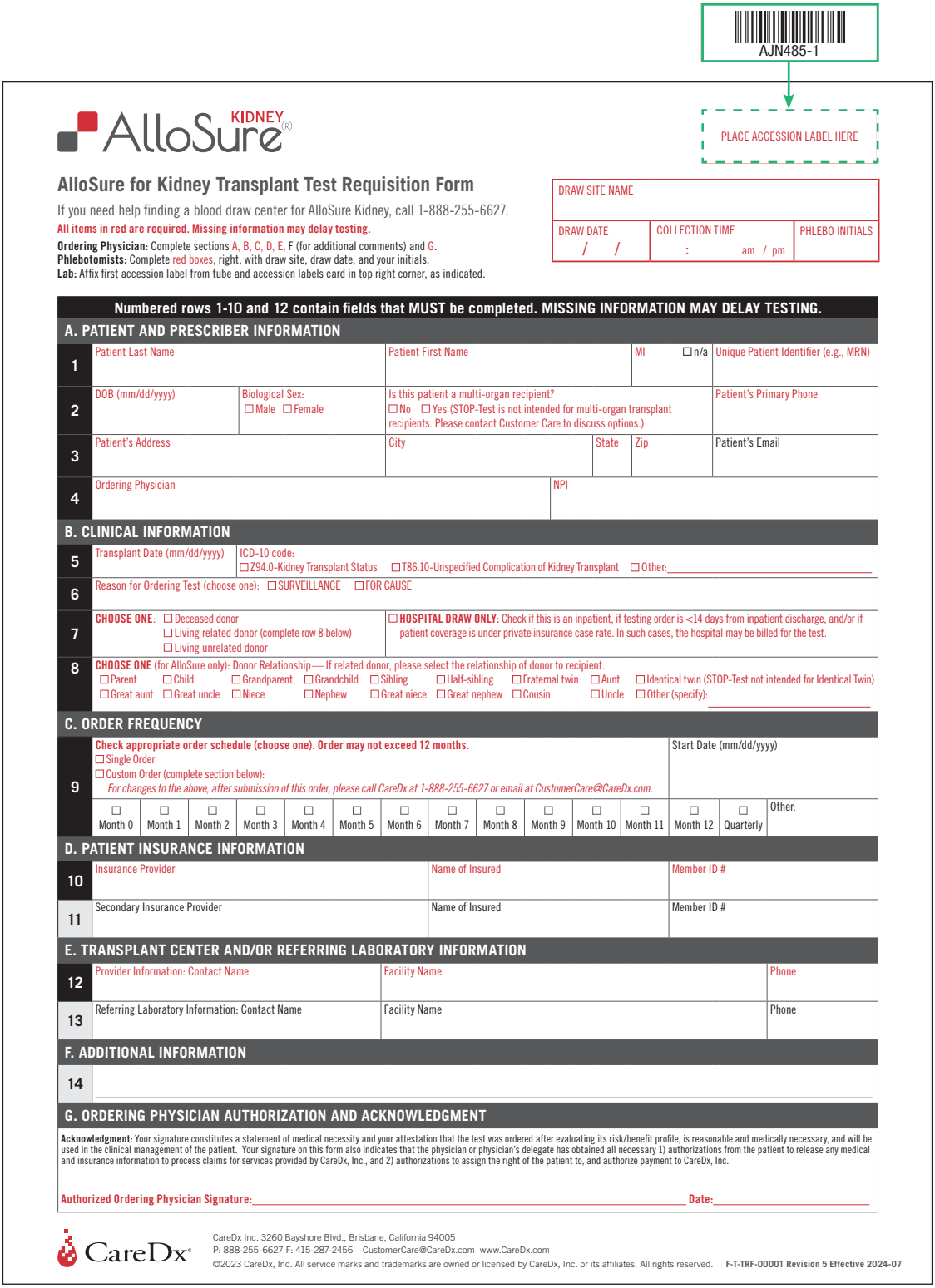
- Use printed label for each tube
- Ensure the label has
  - Name
  - DOB
  - Collection information
- Add a small accession label from the Label Card to the top right corner of your order, and also below your lab label on each tube.



Label for top right of Order

Completing the Order

- Place an accession bar code in the top right corner for any type of order (e.g. EMR, paper, CarePortal, etc.)
- Write in draw site name
- Complete draw date/collection time/and phlebotomist initials



AJN485-1

PLACE ACCESSION LABEL HERE

AlloSure® KIDNEY

AlloSure for Kidney Transplant Test Requisition Form

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

All items in red are required. Missing information may delay testing.

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

DRAW SITE NAME		
DRAW DATE / /	COLLECTION TIME : am / pm	PHLEBO INITIALS

Numbered rows 1-10 and 12 contain fields that MUST be completed. MISSING INFORMATION MAY DELAY TESTING.

A. PATIENT AND PRESCRIBER INFORMATION

1	Patient Last Name	Patient First Name	MI ☐n/a	Unique Patient Identifier (e.g., MRN)	
2	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	
3	Patient's Address	City	State	Zip	Patient's Email
4	Ordering Physician	NPI			

B. CLINICAL INFORMATION

5	Transplant Date (mm/dd/yyyy)	ICD-10 code: ☐Z94.0-Kidney Transplant Status ☐T86.10-Unspecified Complication of Kidney Transplant ☐Other:_____
6	Reason for Ordering Test (choose one): ☐SURVEILLANCE ☐FOR CAUSE	
7	**CHOOSE ONE:** ☐Deceased donor ☐Living related donor (complete row 8 below) ☐Living 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.
8	**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):_____	

C. ORDER FREQUENCY

9	**Check appropriate order schedule (choose one). Order may not exceed 12 months.** ☐Single Order ☐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:

D. PATIENT INSURANCE INFORMATION

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

E. TRANSPLANT CENTER AND/OR REFERRING LABORATORY INFORMATION

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

F. ADDITIONAL INFORMATION

14	_____

G. ORDERING PHYSICIAN AUTHORIZATION AND ACKNOWLEDGMENT

Acknowledgment: Your signature constitutes a statement of medical necessity and your attestation that the test was ordered after evaluating its risk/benefit profile, is reasonable and medically necessary, and will be used in the clinical management of the patient. Your signature on this form also indicates that the physician or physician's delegate has obtained all necessary 1) authorizations from the patient to release any medical and insurance information to process claims for services provided by CareDx, Inc., and 2) authorizations to assign the right of the patient to, and authorize payment to CareDx, Inc.

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

CareDx®

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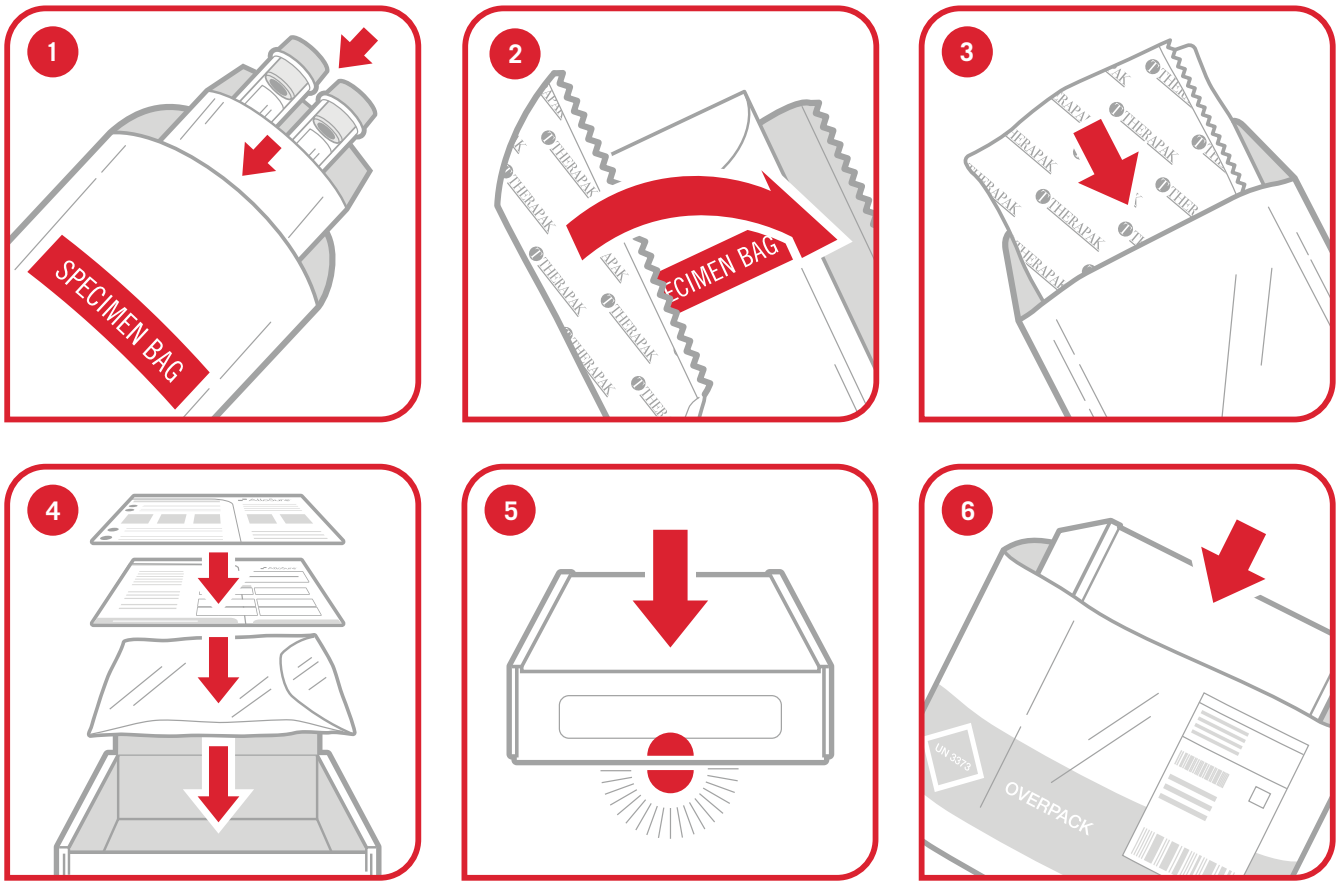
 F-T-TRF-00001 Revision 5 Effective 2024-07

Packaging and Shipping

1. Place the tubes in the absorbent pouch and place pouch in the specimen bag and seal.
2. Wrap the specimen bag in the gel pack.
3. Place gel pack in foil pouch and seal.
4. Place pouch in kit box. Place the order form and Tube & Accession Labels card on top of pouch. Place List of Contents card on top.
5. Close the kit box.
6. Place the box inside the labeled shipping courier bag. Seal and send.

SPECIMENS SHOULD BE SHIPPED SAME DAY. SPECIMEN MUST ARRIVE AT CAREDX WITHIN SEVEN DAYS OF DRAW.



If you have any questions, please contact us:

Customer Service
Phone: 888-255-6627 (888-AlloMap)
Email: csr@caredx.com

Supplies

Email: ordersupplies@caredx.com

Your personal CareDx representative

INSERT First and Last Name, title
Mobile: XXX-XXX-XXX
Email: XXX@caredx.com

CareDx®

US-MKT-LBL-IFU-000001 v.1 Effective 08-2024