



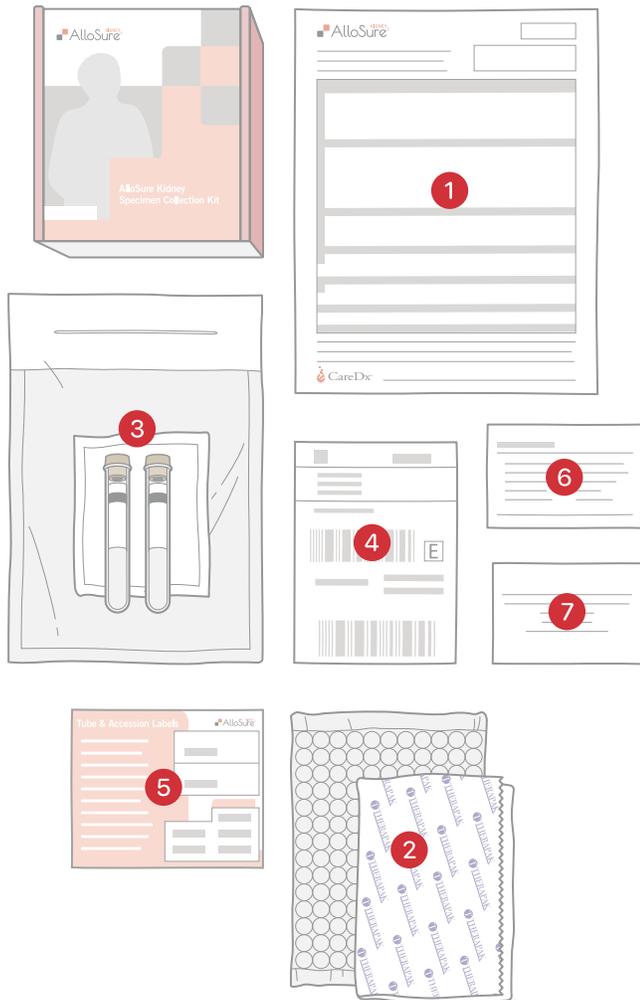
# AlloSure Draws

## Kidney and Lung



Your kit may look different than what is pictured here

# AlloSure Kit Contents



## Therapak

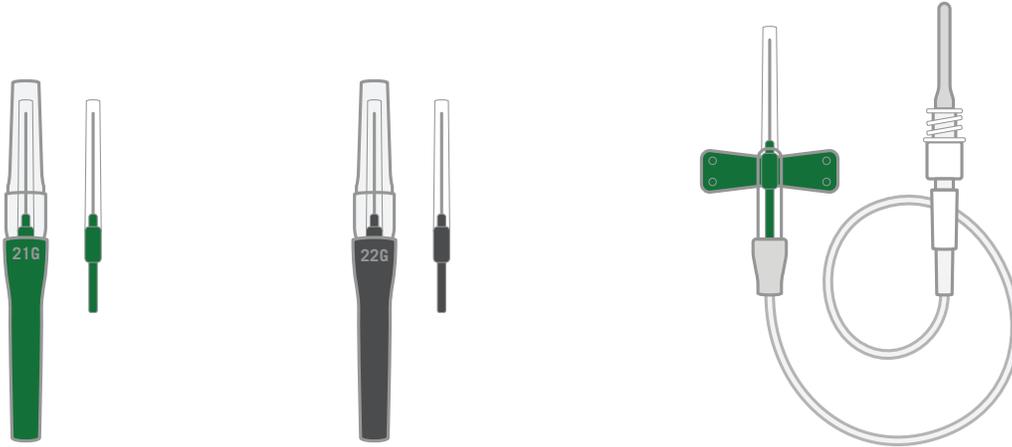
- 1 Test Requisition Form
- 2 Foil pack/gel pack/specimen bag
- 3 2 Streck tubes in absorbent pouch inside specimen bag
- 4 Shipping bag / shipping label
- 5 Label card for tubes
- 6 List of Contents card
- 7 Streck tube card (optional)

## BioTouch

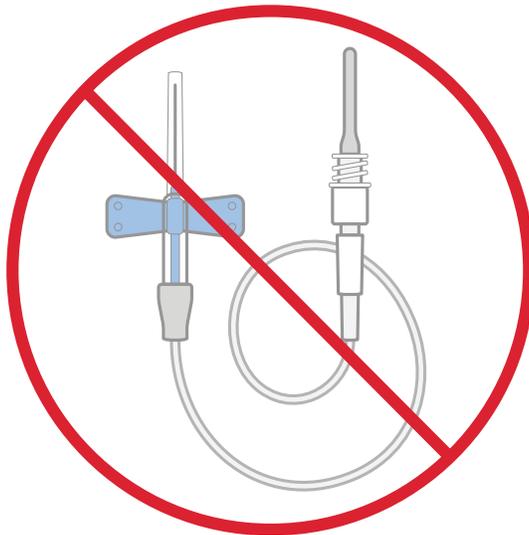
- 1 Quick Draw Instructions
- 2 Foil pack/gel pack/specimen bag
- 3 2 Streck tubes in absorbent pouch inside specimen bag
- 4 Shipping bag / shipping label
- 5 Label card for tubes
- 6 List of Contents card
- 7 Streck tube card (optional)

## 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.

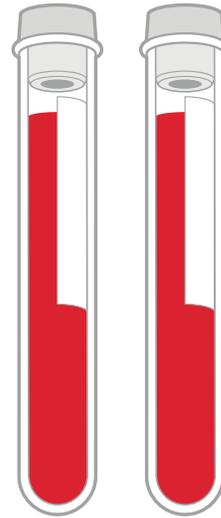


**Use no smaller than a 22 gauge needle when drawing AlloSure specimens.**

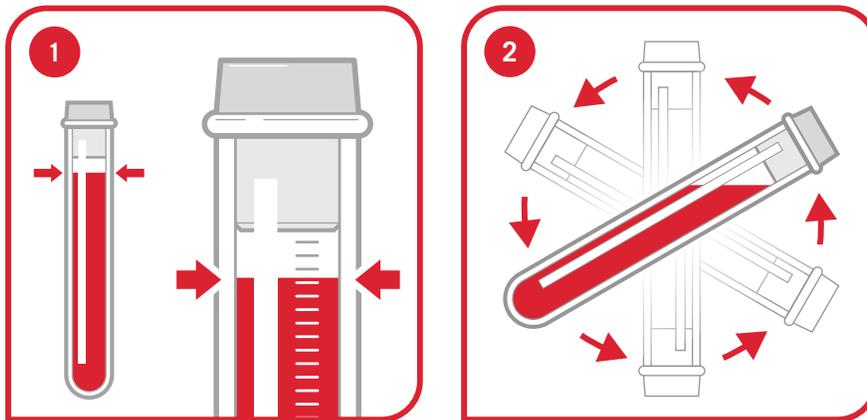


# Draw Instructions

- 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.



# 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.

### Tube & Accession Labels

AlloSure Instructions for Labs

**SPECIMEN COLLECTION & LABELING**

1. Complete the specimen labels, right. Date is MM/DD/YYYY. Do not write on the barcode.
2. If using lab generated labels, they must include patient name, DOB, draw date, and phlebotomist initials. Affix a white barcode label to the tube.
3. Completely fill Streck tubes. If you cannot fill both tubes, collect as much as possible and send. Mix by gentle inversion.
4. Affix the labels lengthwise to the tubes. Do not cover the tube's expiration date.
5. Order form must include patient name, DOB, ordering physician, name of lab, draw date, and phlebo initials. Affix a barcode label to the upper right corner.

**STORING, PACKING, AND SHIPPING**

1. Place the tubes in the absorbent pouch
2. Place the pouch in the 95 kPa bag; seal
3. Wrap the 95 kPa bag in the gel pack and place inside the foil envelope; seal.
4. Place envelope in the shipper box
5. Place order form and this Tube & Accession Labels card on top of the envelope.
6. Place the List of Contents card on top of everything; close and seal the box.
7. Place the box inside the labeled FedEx shipping envelope, seal, and send.

KEEP SPECIMEN AT 6°–37°C. SHIP AS SOON AS POSSIBLE. SPECIMEN MUST ARRIVE AT CAREDX WITHIN 7 DAYS OF DRAWING.

For questions call: 888-255-6627

Ranganathan, Shiyali R  
 6455765433431      09-AUG-1959   65y M



HM-09-132-00234\*0000043456753

Col: 05-MAY-2024 17:43 Site: L Arm      byID0047  
 Comp. Chem. Mg, Osm, Li



AJN485-1

Label for top right of Order

**CareDx**  
Your Partner in Transplant Care™

## Commercial Universal Accession Labels

**Blood Tube Labels Required Information:**

- Patient First & Last Name
- Date of Birth MM/DD/YYYY
- Draw Date MM/DD/YYYY

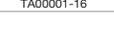
**Attach to Requisition Form:**

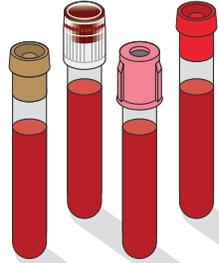


TA00001

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**Extra Accession Labels**

 TA00001-9	 TA00001-13
 TA00001-10	 TA00001-14
 TA00001-11	 TA00001-15
 TA00001-12	 TA00001-16



Kit contents and tubes may vary.

# 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



PLACE ACCESSION LABEL HERE



## 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	<input type="checkbox"/> n/a	Unique Patient Identifier (e.g., MRN)						
2	DOB (mm/dd/yyyy)		Biological Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Is this patient a multi-organ recipient? <input type="checkbox"/> No <input type="checkbox"/> 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: <input type="checkbox"/> Z94.0-Kidney Transplant Status <input type="checkbox"/> T86.10-Unspecified Complication of Kidney Transplant <input type="checkbox"/> Other: _____												
6	Reason for Ordering Test (choose one): <input type="checkbox"/> SURVEILLANCE <input type="checkbox"/> FOR CAUSE														
7	<b>CHOOSE ONE:</b> <input type="checkbox"/> Deceased donor <input type="checkbox"/> Living related donor (complete row 8 below) <input type="checkbox"/> Living unrelated donor				<b>HOSPITAL DRAW ONLY:</b> 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	<b>CHOOSE ONE</b> (for AlloSure only): Donor Relationship—If related donor, please select the relationship of donor to recipient. <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Grandparent <input type="checkbox"/> Grandchild <input type="checkbox"/> Sibling <input type="checkbox"/> Half-sibling <input type="checkbox"/> Fraternal twin <input type="checkbox"/> Aunt <input type="checkbox"/> Identical twin (STOP-Test not intended for Identical Twin) <input type="checkbox"/> Great aunt <input type="checkbox"/> Great uncle <input type="checkbox"/> Niece <input type="checkbox"/> Nephew <input type="checkbox"/> Great niece <input type="checkbox"/> Great nephew <input type="checkbox"/> Cousin <input type="checkbox"/> Uncle <input type="checkbox"/> Other (specify): _____														
C. ORDER FREQUENCY															
9	<b>Check appropriate order schedule (choose one). Order may not exceed 12 months.</b> <input type="checkbox"/> Single Order <input type="checkbox"/> Custom Order (complete section below): <i>For changes to the above, after submission of this order, please call CareDx at 1-888-255-6627 or email at CustomerCare@CareDx.com.</i>										Start Date (mm/dd/yyyy)				
	<input type="checkbox"/> Month 0	<input type="checkbox"/> Month 1	<input type="checkbox"/> Month 2	<input type="checkbox"/> Month 3	<input type="checkbox"/> Month 4	<input type="checkbox"/> Month 5	<input type="checkbox"/> Month 6	<input type="checkbox"/> Month 7	<input type="checkbox"/> Month 8	<input type="checkbox"/> Month 9	<input type="checkbox"/> Month 10	<input type="checkbox"/> Month 11	<input type="checkbox"/> Month 12	<input type="checkbox"/> 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															
<b>Acknowledgment:</b> 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: _____				



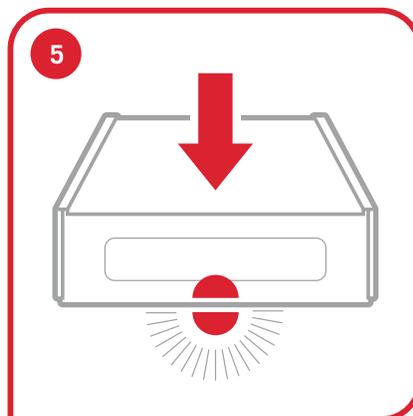
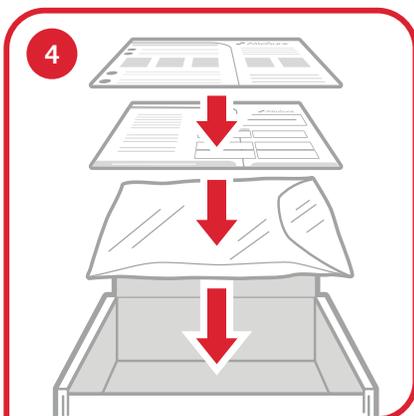
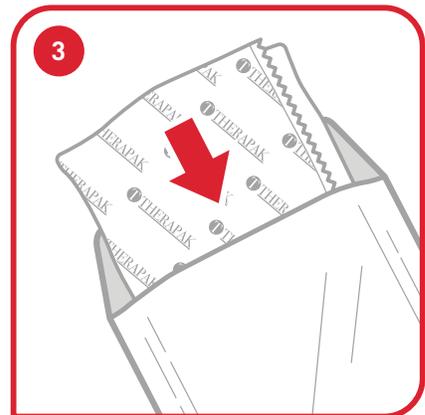
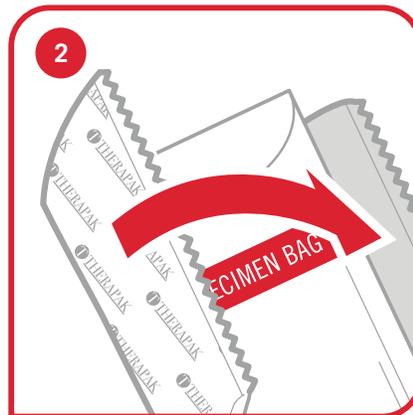
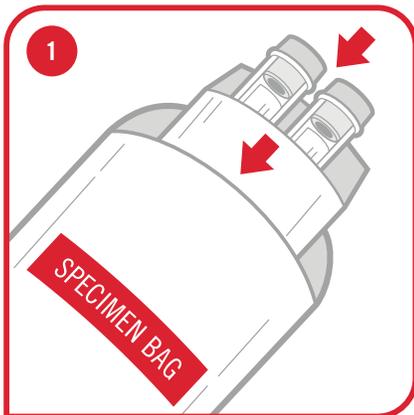
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# Packaging and Shipping

- 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](mailto:csr@caredx.com)

**Supplies**

**Email:** [ordersupplies@caredx.com](mailto:ordersupplies@caredx.com)

**Your personal CareDx representative**

