TEST REQUISITION FORM

Please fax to: +1 (617) 418-2290
Email: client.services@foundationmedicine.com

FOUNDATIONFOCUS™ CDx *BRCA*

*Required Information

☐ Associated Study ID _____

For more information or to order online, ***visit www.foundationmedicine.com/genomic-testing/order***

Patient Information

*Last Name | *First Name | MI | *Medical Record # | *DOB (MM/DD/YYYY) | *Sex ☑ F ☐ M

*Street Address | Apt. # | *City | *State | *Postal Code | *Country | *Phone (primary)

Has the patient received prior Foundation Medicine Testing? ☐ N ☐ Y If yes, Associated Requisition # _____

Has the patient received any targeted therapies? ☐ N ☐ Y If yes, details: _____

Has the patient received any type of transplant? ☐ N ☐ Y If yes, details: _____

Diagnosis & Specimen Information

*Diagnosis Ovarian Cancer

Subtype: _____

*ICD Code(s) _____

*Stage _____

*Specimen Site _____

*Date of Collection (MM/DD/YYYY) _____

Specimen Retrieval | *Only one specimen can be tested per order*

Foundation Medicine will contact the pathology department (must be indicated below) to request your patient's specimen. **Please select at least one specimen option below.*

☐ Preferred Specimen for Testing: Specimen ID _____

Alternate Choice: Specimen ID _____

☐ Pathologist Choice _____

☐ ***DO NOT*** contact pathology regarding this case. I will arrange for the specimen to be shipped to Foundation Medicine.

Pathology Information

Submitting Pathologist Name _____

Facility _____

Phone _____ Fax _____

Ordering Physician Information

*Facility Name | *Ordering Physician Name

*Street Address

*City | *State | *Postal Code | *Country

*Phone | *Fax

*Email | *Account #

Additional Physician to be Copied:

Facility | Name

Email | Fax

Technical Information

Intended Use The FoundationFocus™ CDx *BRCA* is a next generation sequencing-based *in vitro* diagnostic device for qualitative detection of *BRCA1* and *BRCA2* alterations in formalin-fixed paraffin-embedded (FFPE) ovarian tumor tissue. The FoundationFocus CDx *BRCA* assay detects sequence alterations in *BRCA1* and *BRCA2* (*BRCA1/2*) genes. Results of the test are used as an aid in identifying ovarian cancer patients for whom treatment with Rubraca® (rucaparib) is being considered. If a patient is positive for any of the deleterious alterations specified in the *BRCA1/2* classification, the patient may be eligible for treatment with Rubraca®. This assay is to be performed at Foundation Medicine, Inc., a single laboratory site located at 150 Second Street, Cambridge, MA 02141. Rubraca® is a registered trademark of Clovis Oncology. For additional information on the assay and detailed performance specifications, refer to the complete FoundationFocus™ CDx *BRCA* label at *www.foundationmedicine.com/genomic-testing/foundation-focus.*

Required Attachments

☐ Copy of recent pathology/cytology reports

☐ Test results from all other Molecular Diagnostic Assays by FISH, IHC, or other genetic assays, e.g., *ER, PR, HER2, EGFR, KRAS,* etc.

Billing Information | *Select one of the four payment options and complete all fields indicated*

☐ **Insurance:** Policy # _____ Group # _____ Insurance Name _____

Insured Name _____ ☐ Front/back copy of insurance card attached

☐ **Facility:** _____ Address _____ ☐ Same as ordering physician

☐ **Medicare – Part B:** Policy # _____ Select Patient Status below *(must be filled out for all Medicare):*

☐ Office (non-hospital) ☐ Outpatient ☐ Inpatient: Requires discharge date (MM/DD/YYYY) _____

☐ **Self-Pay:** Contact Name _____ Phone _____ Email _____

Certificate of Medical Necessity/Consent

My signature constitutes a Certificate of Medical Necessity and certifies that I have explained to the patient the nature and purpose of the testing to be performed and have obtained informed consent, to the extent legally required, to permit Foundation Medicine to (a) perform the testing specified herein, (b) retain the test results for an indefinite period for internal quality assurance/operations purposes, (c) de-identify the test results and use or disclose such de-identified results for future unspecified research or other purposes, and (d) release the test results to the patient's third-party payer as needed for reimbursement purposes.

Physician Signature

I am submitting my patient's ovarian cancer specimen for FoundationFocus CDx *BRCA* testing.

*Ordering Physician Signature _____

*Date (MM/DD/YYYY) _____