Test Requisition Form

Vectra®

SPECIMEN COLLECTION & PROCESSING DATE	TIME OF COLLECTION:
_____ MM _____ DD _____ YYYY	_____ : _____ ☐ AM ☐ PM

BLOOD DRAW LOCATION

☐ **OFFICE OF ORDERING PROVIDER**
No further information required

☐ **OTHER LAB:**
Laboratory Name / Site Code:

AFFIX ONE BARCODE HERE

Affix one barcode label to the specimen tube and one below to the test requisition form here.

Extra barcode labels have been provided.

1. Ordering Physician Account Information

Last Name	First Name	Email
NPI # (National Provider Number)	Clinic Name or Institution Name	
Account #	Phone	Fax
Address	City	State / Zip

2. Patient Information

Last Name	First Name	M.I.	Gender	Birth Date
			☐ Male ☐ Female	
Email			Cell or Primary Phone	
Address	City		State	Zip

3. Billing Information

Reminder: Include a copy of BOTH SIDES of your insurance card(s). If you submit more than one card, indicate which is primary.

PATIENT'S INSURANCE INFORMATION (Please attach copy of group number)

Name of Policy Holder: _____ DOB: _____ Insurance ID#: _____

Patient Relation to Policy Holder: ☐ Self ☐ Spouse ☐ Other Group Number _____

Patient Financial Assistance & Resources:

☐ I would like to be considered for financial assistance through Crescendo Bioscience. ☐ I would like to receive information on resources associated with my test result.

SIGN HERE: PATIENT X _____ Date: _____

OTHER BILLING ☐ Bill our institutional account #_____. ☐ Established research project code#_____

4. ICD-10 Codes

Please provide the applicable ICD-10 code(s). For your reference, some of the ICD-10 codes that describe adult rheumatoid arthritis begin with M05 or M06.

Primary ICD-10 Code:				Secondary ICD-10 Code	
	☐ M06.09	☐ M06.89	☐ M05.841	_____	**Regardless of whether listed herein,** you should refer to the ICD-10 Code Book when making your diagnosis and report only the diagnosis code(s) you have independently determined are appropriate based on documentation in your patient medical record.
	☐ M06.041	☐ M05.79	☐ M05.842		
	☐ M06.042	☐ M05.89	☐ Other: _____		

5. Test Requested

☑ **Vectra®**

An order for Vectra DA includes and requires an order for 12 biomarkers: VCAM-1, EGF, VEGF-A, IL-6, TNF-RI, MMP-1, MMP-3, YKL-40, Leptin, Resistin, SAA, CRP. These 12 biomarkers are required to generate the Vectra DA test score. By ordering Vectra DA, you are ordering all 12 biomarkers and are acknowledging that we cannot provide a Vectra DA test result without these 12 biomarkers. Vectra DA was validated in adults with Rheumatoid Arthritis (RA). Test results are intended to aid in the assessment of disease activity in RA patients when used in conjunction with standard clinical assessment.

6. Statement of Medical Necessity

I affirm the following: My signature constitutes a certification of Medical Necessity; this test is medically necessary for the treatment and management of the patient. The findings of the test will be used in the patient's medical management and treatment decisions. The person listed as the Ordering Physician is authorized by law to order the test requested herein.

SIGN HERE ORDERING PHYSICIAN (required to process form) X _____ Date: _____

Crescendo Bioscience, Inc. a Myriad Genetics Company
320 Wakara Way, Salt Lake City, UT 84108
vectrada.com | Fax: 1-877-743-8640 | TOLL-FREE: 1-877-743-8639

IMPORTANT INFORMATION FOR PATIENT

FINANCIAL ASSISTANCE: Vectra® Financial Assistance CARE Program

- Vectra Customer Service and Billing will work with your insurance provider to help you get the appropriate coverage. Your cost will depend on your health care plan and your ability to pay. Payment plans and financial assistance may be available through the CARE program.
- CARE Patient Certification: If I do not have insurance, I certify I am not eligible for Medicare, Medicaid, or any other state or government health insurance and will not seek reimbursement from any insurance carrier or government agency for Vectra fees waived.
- If I have insurance, I certify that I will not seek reimbursement from any insurance carrier or government agency for Vectra fees that are my financial responsibility.
- I certify that the information contained in this application is correct to the best of my knowledge. I understand this information will not be used for any other purpose unless I give written consent, or to the extent necessary to document my eligibility under the CARE program.
- I certify I will notify the Vectra Financial Assistance CARE Program within 30 days if there is any change in my eligibility status with regard to income and health care coverage. I will provide documentation, including but not limited to personal financial records, which are necessary to verify the information contained in this application.
- By agreeing to Vectra testing, I authorize Vectra Billing to obtain a consumer credit report on me from a consumer reporting agency selected by Vectra Billing. I understand and agree that Vectra Billing may use my consumer credit report to confirm whether my income qualifies me for financial assistance. I further understand that this will be a soft credit inquiry and will not impact my credit in any way.
- If I qualify for financial assistance, I agree to provide Vectra Billing with any additional information or documentation that may be needed to confirm my qualification for the financial assistance program.

TEST SUBMISSION INSTRUCTIONS: USE THESE TEST SUBMISSION GUIDELINES TO AVOID DELAYS AND TO ENSURE TIMELY SPECIMEN DELIVERY

SPECIMEN COLLECTION AND PROCESSING

- Ensure that the PolarPack® FoamBricks have been frozen (-5˚C/23˚F) for at least 24 hours.
- Ensure that the expiration date on the BD Serum Separator Transport™ (SST) tube* has not passed.
- Keep a copy of the test requisition form (TRF) for your records.
- Specimens must be received by Crescendo Bioscience Inc., a Myriad Genetics Lab within 7 days of collection.
- Place 1 Specimen Barcode Label in the designated area of the TRF.
- Write patient's DOB, first and last name on the Patient Specimen Barcode Label.
- Place the Patient Specimen Barcode Label lengthwise onto the SST tube.
- Fill the SST tube with at least 4mL of blood.
- Gently mix by inverting at least 5 times.
- Allow to clot at room temperature (20-25˚C) for 30-120 minutes.
- Centrifuge for 15 minutes (1100-1300 RCF at room temp) in a swinging bucket or fixed angle centrifuge.

STORING, PACKING AND SHIPPING

- Place the specimen and the TRF in the refrigerator until shipping pick up time.
- Specimen must remain in the refrigerator if not picked up the same day collected.
- Use another properly labeled Vectra kit box if the outer box doesn't have a pre-applied FedEx label.
- Place 1 frozen PolarPack FoamBrick in the bottom of the foam cooler.
- Each specimen should be in its own white absorbent tube sleeve and biohazard bag.
- The TRF(s) should be placed in the side pouch of the biohazard bag(s). Please provide a copy of the front and back of the patient's insurance or Medicare or Medicaid card(s).
- Up to 5 specimens can be shipped in the cooler.
- Place a 2nd frozen PolarPack FoamBrick on top of the specimen(s).
- Call for the specimen pick up.
- FedEx confirmation # _____

FOR SPECIMEN PICKUP, CALL FEDEX AT 1-800-463-3339 OR GO TO WWW.FEDEX.COM
and say, "Schedule a pick-up using a label."

FOR QUESTIONS REGARDING THE SPECIMEN, PLEASE CONTACT VECTRA CUSTOMER SERVICE AT 1-877-743-8639.

Vectra DA is validated for use in adults diagnosed with RA. Test results are intended to aid in the assessment of disease activity in RA patients when used in conjunction with standard clinical assessment. This test is not intended or validated to diagnose RA.