BOSTWICK LABORATORIES
A DIVISION OF POPLAR HEALTHCARE

3495 Hacks Cross Road,
Memphis, TN 38125
www.poplarhealthcare.com

BU160000000

Highlighted areas must be completed!

PHYSICIAN INFORMATION

Requesting Physician's Signature * (SEE BACK FOR MEDICAL ATTESTATION STATEMENT): ______

Send Duplicate Report To:
PHYSICIAN: ______

FAX: ______

PATIENT INFORMATION

LAST NAME: ______ FIRST NAME: ______ M.I.: ______

STREET ADDRESS: ______

CITY: ______ STATE: ______ ZIP CODE: ______

SEX: ☐ M ☐ F SSN: ______ DOB: ______
Only last 4 digits of SSN required. MM/DD/YYYY

CHART NO.: ______

TELEPHONE NO. H.: ______ W. : ______

RACE/ETHNIC IDENTIFICATION: ☐Asian ☐ African-American ☐ Caucasian ☐Hispanic
☐ Pacific Islander ☐ Native-American ☐ Other: ______

BILLING INFORMATION

PLEASE ATTACH COPIES OF BOTH CARDS, FRONT AND BACK

PRIMARY INSURANCE

BILL: ☐ Medicare ☐ Medicaid ☐ Insurance ☐ Self Pay ☐ Ordering Physician (no ins. info needed)
☐ Billing Information Attached

(Medicare only) Facility where procedure was performed (In-Office/Hospital Outpatient/Hospital Inpatient): ______

If Hospital Inpatient, Indicate Discharge Date: ______

POLICY/ID NO.: ______ GROUP NO.: ______

INSURED'S NAME: ______ SSN: ______ DOB: ______
Only last 4 digits of SSN required. MM/DD/YYYY

INSURANCE CARRIER: ______

CLAIM ADDRESS: ______

CITY: ______ STATE: ______ ZIP CODE: ______

PHONE NO.: ______

SECONDARY INSURANCE (Please attach copies of both cards, front and back.)
Bill: ☐ Medicare ☐ Medicaid ☐ Insurance ☐ Self Pay ☐ Ordering Physician
☐ Billing Information Attached (no ins. info needed)

POLICY/ID NO.: ______ GROUP NO.: ______

INSURED'S NAME: ______ SSN: ______ DOB: ______
Only last 4 digits of SSN required. MM/DD/YYYY

INSURANCE CARRIER: ______

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HISTOLOGY

ICD CODE: ______ No. of Vials Submitted: ______

COLLECTION DATE: ______

☐ Saturation Biopsy Performed *(see reverse for biopsy requirements)*

PSA†: ______ ng/ml Date: ______ DRE†: ☐ Normal ☐ Abnormal

†PSA & DRE required for ConfirmMDx and for UroPredict® staging report

Previous Biopsy: ☐ None ☐ Benign ☐ Suspicious/ASAP ☐ HGPIN ☐ Malignant
Previous Therapy: ☐ Hormonal ☐ Surgery ☐ Radiation ☐ Chemotherapy ☐ Cryosurgery
☐ HIFU ☐ Other ______

Clinical information required for Genomic testing:
Pre-Biopsy PSA (ng/mL) ______
Prior Radiation or Hormone Therapy: ☐ No ☐ Yes ***(patient ineligible for testing)***
Clinical Stage: ☐ T1a ☐ T1b ☐ T1c ☐ T2a ☐ T2b ☐ T2c ☐ T3a ☐ T3b ☐ T4
Prostate Volume ______
Please include any medical notes: ______

Pre Treatment Recommendation (Radical Prostatectomy / External Beam Radiation / Brachytherapy / Active Surveillance / Other: (specify)): ______

TEST REQUESTED *(See reverse for test panel components)*

☐ Prostate Histology
Reflex Options: You may select up to two reflex options (one pos/one neg):
☐ ConfirmMDx on benign or HGPIN
☐ ProstaVysion on Gleason 6&7
☐ Decipher® Biopsy on Gleason 6&7
☐ Oncotype DX® GPS on Gleason 6&7*
**For Gleason 6 or 3+4=7 and 4+3 w/only 1 positive core*

☐ Bostwick Blueprint for Prostate
(Histology w/ reflex ProstaVysion GS 6&7 ConfirmMDx on benign or HGPIN)

☐ Bladder Histology
☐ BladderVysion
☐ Rule Out IC (Interstitial Cystitis)

☐ Vas Deferens Histology

☐ Other: ______

PROGNOSTIC MARKERS
☐ MIB-1/Ki-67 ☐ Bcl-2

PANELS performed on previously diagnosed histology cases)
☐ ConfirmMDx on benign or HGPIN
☐ ProstaVysion on Gleason 6&7
☐ BladderVysion
☐ Decipher® Biopsy on Gleason 6&7
☐ Oncotype DX® GPS on Gleason 6&7*
**For Gleason 6 or 3+4=7 and 4+3 w/only 1 positive core*

Previous Histology Case Accession Number:
(example: BL16-0105-9999999)
______

Note: Pathologist may order stains or additional tests when required for diagnosis. Reflex testing and additional stains will incur additional charges.

CYTOLOGY

ICD CODE: ______

COLLECTION DATE: ______ Collection Time: ______ ☐AM ☐PM

Specimen Type
☐ First Morning Void
☐ Catheterized Urine
☐ Bladder Wash
☐ Renal Wash: ☐ *Left* ☐ *Right*
☐ Post Cystoscopy Void
☐ Random Void
☐ Ileal Conduit/Neobladder
☐ Other: ______

Cystoscopy
☐ Normal ☐ Abnormal

Relevant History
☐ Bladder Ca ☐ CIS
☐ Diabetes ☐ Hypertension
☐ Renal Transplant ☐ Hematuria
☐ Other: ______

Previous Therapy
☐ BCG ☐ Radiation
☐ TURB ☐ Chemotherapy
☐ Other: ______

Previous Cytology
Date: ______
Dx: ☐ None ☐ Neg.
☐ Atypia ☐ Malignant

TEST REQUESTED
(See reverse for test panel components)

Please select the appropriate cytology test from the menu below. FISH options must be checked to be performed.

Note: Reflex tests are performed on atypical or suspicious diagnoses.

Cytology, MicroVysion and FISH Options	Reflex FISH Options	FISH Options
☐ Cytology	☐ With reflex FISH	☐ With FISH
☐ Cytology with Telomerase	☐ With reflex FISH	☐ With FISH
☐ CytologyPro *(Cytology with acid hematoxylin (AH) or Feulgen stain)*	☐ With reflex FISH	☐ With FISH
☐ CytologyPro XT *(Cytology, with Acid Hematoxylin (AH) or Feulgen, and telomerase stain)*	☐ With reflex FISH	☐ With FISH
☐ 3-Day Cytology	☐ With reflex FISH	☐ With FISH
☐ 3-Day Cytology with Telomerase	☐ With reflex FISH	☐ With FISH
☐ 3-Day CytologyPro *(Cytology with acid hematoxylin (AH) or Feulgen stain)*	☐ With reflex FISH	☐ With FISH
☐ 3-Day CytologyPro XT *(Cytology, with Acid Hematoxylin (AH) or Feulgen, and telomerase stain)*	☐ With reflex FISH	☐ With FISH
☐ MicroVysion	☐ With reflex FISH	☐ With FISH
☐ MicroVysion XT	☐ With reflex FISH	☐ With FISH
☐ FISH	☐ Other ______	

Note: MicroVysion is not performed on washings or ileal conduit. Pathologist may order stains or additional tests when required for diagnosis. Reflex testing and additional stains will incur additional charges.

BOSTWICK LAB COPY

SPECIMEN LABEL INSTRUCTIONS:
1. Complete the requisition with all requested information.
2. Clearly print the patient name—do NOT write on the bar code.
3. Place one (1) label on each specimen container (not on the lid).
4. Please discard any unused vials.

BU160000000 LEFT LATERAL BASE PATIENT NAME	BU160000000 LEFT BASE PATIENT NAME	BU160000000 RIGHT BASE PATIENT NAME	BU160000000 RIGHT LATERAL BASE PATIENT NAME	BU160000000 CENTRAL BASE PATIENT NAME
BU160000000 LEFT LATERAL MID PATIENT NAME	BU160000000 LEFT MID PATIENT NAME	BU160000000 RIGHT MID PATIENT NAME	BU160000000 RIGHT LATERAL MID PATIENT NAME	BU160000000 CENTRAL MID PATIENT NAME
BU160000000 LEFT LATERAL APEX PATIENT NAME	BU160000000 LEFT APEX PATIENT NAME	BU160000000 RIGHT APEX PATIENT NAME	BU160000000 RIGHT LATERAL APEX PATIENT NAME	BU160000000 CENTRAL APEX PATIENT NAME
BU160000000 LEFT SEMINAL VESICLE PATIENT NAME	BU160000000 LEFT PATIENT NAME	BU160000000 RIGHT PATIENT NAME	BTP160001 RIGHT SEMINAL VESICLE PATIENT NAME	BU160000000 SITE ______ PATIENT NAME
BU160000000 MICROVYSION PATIENT NAME	BU160000000 CYTO./CYTOLOGY PRO/XT/FISH PATIENT NAME	BU160000000 PCA3PLUS PATIENT NAME	BU160000000 PROSTA~SEQ PATIENT NAME	BU160000000 SITE ______ PATIENT NAME

MEDICAL NECESSITY INFORMATION

It is our policy to provide health care providers with the ability to order only those lab tests medically necessary for the individual patient and to ensure that the convenience of ordering standard panels and custom profiles does not impact this ability. While we recognize the value of this convenience, indiscriminate use of panels and profiles can lead to ordering tests that are not medically necessary. Therefore, all tests offered in our panels and profiles can be ordered individually. If a component of a test is not listed individually on the request form, it may be written on the line labeled "OTHER" within that test section. We encourage you to order individual tests or a less inclusive profile when not all of the tests included in the panel or profile are medically necessary for the individual patient.

Test Panels Offered by Bostwick Laboratories	
BladderVysion™	**MicroVysion®**
FGFR3 Stain	Automated Chemistry w/o scope-Urine
Ki-67 Stain	Beta-2 Microglobulin-Urine
p53 Stain	Cytology, Liquid Base
PTEN FISH	Acid Hematoxylin or Feulgen stain
	Microalbumin, Quantitative-Urine
CytologyPro™	Creatinine-Urine
Cytology	Protein-Urine
Acid Hematoxylin or Feulgen Stain	**MicroVysion XT**
	The components listed above plus Telomerase (Anti-h TERT) Stain
CytologyPro XT™	
Cytology	**ProstaVysion™**
Acid Hematoxylin or Feulgen Stain	ERG Stain
Telomerase (Anti-h TERT) Stain	PTEN FISH

Saturation Biopsy Requirements
Patient insurance pre-authorization or appropriate clinical history documenting clinical necessity is required for saturation biopsy cases.

Explanation of Reflex Test Offerings

Below are the description of the test panels and shown on the front of the requisition. By requesting any of the below test panels on the requisition, you are acknowledging that all components of the panel are medically necessary for the diagnosis and treatment of the patient.

Explanation of Prostate Histology Reflex Order Options

(See test panel components below)

- » **ProstaVysion on Gleason 6&7:** Prostate histology will reflex to ProstaVysion with a Gleason 6 or 7 diagnosis
- » **ConfirmMDx on benign or HGPIN:** Prostate histology will reflex to ConfirmMDx on a benign or HGPIN diagnosis (Not performed on ASAP).
- » ***Genomic Health® Oncotype DX® Genomic Prostate Score:** Prostate histology will reflex to Oncotype DX® GPS with a Gleason 6 (3+3) or 7 (3+4 or 4+3 w/ only 1 positive core) diagnosis.
- » **Decipher Biopsy on Gleason 6&7:** Prostate histology will reflex to Decipher Biopsy with a Gleason 6 or 7 diagnosis.

Explanation of Bladder Histology Reflex Order Options

(See test panel components below)

- » **BladderVysion on positive:** Bladder histology will reflex to BladderVysion on malignant cases.

Explanation of Urine Cytology Reflex Order Options

(See test panel components below)

- » **Cytology w/reflex FISH:** Cytology will reflex to fluorescence in situ hybridization (FISH) on an atypical/suspicious diagnosis.
- » **Cytology w/FISH:** FISH will be performed with Cytology regardless of diagnosis.
- » **Cytology with Telomerase with reflex FISH:** Cytology with Telomerase will reflex to FISH on atypical/suspicious diagnosis.

MEDICAL NECESSITY ATTESTATION

***Genomic Health® Oncotype DX® Genomic Prostate Score**

Your signature constitutes a Statement of Medical Necessity (SOMN) and your attestation of the following: 1) accurate clinical information has been entered above, as this will be used by GHI to automatically calculate the patient's risk group (as indicated in NCCN 2016 v.3) and inaccurate information could impact the test result; 2) if the diagnosis or exception criteria sections of the form do not indicate otherwise, the patient meets the assay criteria; 3) the test is medically necessary and test results will be used with other clinical data to help determine the appropriate treatment plan for the patient; 4) the patient has consented for this test to be performed, and for Genomic Health Inc. to release test information when necessary to obtain reimbursement.

For Medicare Beneficiaries: You further certify that you have completed requisite training and have enrolled in the Genomic Health CTR Program and that the patient meets the Medicare patient eligibility criteria provided on the requisition form instructions.

Explanation of Urine Cytology Reflex Order Options (cont.)

(See test panel components below)

- » **Cytology with Telomerase with FISH:** FISH will be performed with Cytology with Telomerase regardless of diagnosis.
- » **CytologyPro reflex FISH:** CytologyPro XT will reflex to FISH on atypical/suspicious diagnosis.
- » **CytologyPro w/FISH:** FISH will be performed with CytologyPro regardless of diagnosis.
- » **CytologyPro XT reflex FISH:** CytologyPro XT will reflex to FISH on atypical/suspicious diagnosis.
- » **CytologyPro XT w/FISH:** FISH will be performed with CytologyPro XT regardless of diagnosis.
- » **3-Day Cytology:** Cytology tests will be performed over three consecutive days.
- » **3-Day Cytology w/reflexFISH:** 3-Day Cytology will reflex to FISH on an atypical/suspicious diagnosis. FISH will be performed on only one of the three cytology specimens.
- » **3-Day Cytology w/FISH:** FISH will be performed with 3-Day Cytology regardless of diagnosis. FISH will be performed on only one of the three cytology specimens.
- » **3-Day CytologyPro:** CytologyPro tests will be performed over three consecutive days.
- » **3-Day CytologyPro w/reflex FISH:** FISH will be performed with 3-Day CytologyPro on an atypical or suspicious diagnosis. FISH will be performed on only one of the three cytology specimens.
- » **3-Day CytologyPro w/FISH:** FISH will be performed with 3-Day CytologyPro regardless of diagnosis. FISH will be performed on only one of the three cytology specimens.
- » **3-Day CytologyPro XT w/reflex FISH:** FISH will be performed with 3-Day CytologyPro XT on an atypical or suspicious diagnosis. FISH will be performed on only one of the three cytology specimens.
- » **3-Day CytologyPro XT w/FISH:** FISH will be performed with 3-Day CytologyPro XT regardless of diagnosis. FISH will be performed on only one of the three cytology specimens.
- » **MicroVysion with reflex FISH:** MicroVysion will reflex to FISH on an atypical/suspicious diagnosis.
- » **MicroVysion with/FISH:** FISH will be performed with MicroVysion regardless of diagnosis.
- » **MicroVysion XT with reflex FISH:** MicroVysion XT will reflex to FISH on an atypical/suspicious diagnosis.
- » **MicroVysion XT with/FISH:** FISH will be performed with MicroVysion XT regardless of diagnosis.

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Memphis, TN 38125
www.poplarhealthcare.com

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Highlighted areas must be completed!

PHYSICIAN INFORMATION

Requesting Physician's Signature * (SEE BACK FOR MEDICAL ATTESTATION STATEMENT): ______

Send Duplicate Report To:
PHYSICIAN: ______
FAX: ______

PATIENT INFORMATION

LAST NAME: ______ FIRST NAME: ______ M.I.: ______
STREET ADDRESS: ______
CITY: ______ STATE: ______ ZIP CODE: ______
SEX: ☐ M ☐ F SSN: ______ DOB: ______
Only last 4 digits of SSN required. MM/DD/YYYY
CHART NO.: ______
TELEPHONE NO. H.: ______ W.: ______
RACE/ETHNIC IDENTIFICATION: ☐ Asian ☐ African-American ☐ Caucasian ☐ Hispanic ☐ Pacific Islander ☐ Native-American ☐ Other: ______

BILLING INFORMATION

PLEASE ATTACH COPIES OF BOTH CARDS, FRONT AND BACK

PRIMARY INSURANCE
BILL: ☐ **Medicare** ☐ **Medicaid** ☐ **Insurance** ☐ **Self Pay** ☐ **Ordering Physician** (no ins. info needed)
☐ **Billing Information Attached**
(Medicare only) Facility where procedure was performed (In-Office/Hospital Outpatient/Hospital Inpatient): ______
If Hospital Inpatient, Indicate Discharge Date: ______

POLICY/ID NO.: ______ GROUP NO.: ______
INSURED'S NAME: ______ SSN: ______ DOB: ______
Only last 4 digits of SSN required. MM/DD/YYYY
INSURANCE CARRIER: ______
CLAIM ADDRESS: ______
CITY: ______ STATE: ______ ZIP CODE: ______
PHONE NO.: ______

SECONDARY INSURANCE (Please attach copies of both cards, front and back.)
Bill: ☐ **Medicare** ☐ **Medicaid** ☐ **Insurance** ☐ **Self Pay** ☐ **Ordering Physician**
☐ **Billing Information Attached (no ins. info needed)**
POLICY/ID NO.: ______ GROUP NO.: ______
INSURED'S NAME: ______ SSN: ______ DOB: ______
Only last 4 digits of SSN required. MM/DD/YYYY
INSURANCE CARRIER: ______

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PHYSICIAN COPY

SPECIMEN LABEL INSTRUCTIONS:
1. Complete the requisition with all requested information.
2. Clearly print the patient name—do NOT write on the bar code.
3. Place one (1) label on each specimen container (not on the lid).
4. Please discard any unused vials.

HISTOLOGY

ICD CODE: ______ No. of Vials Submitted: ______
COLLECTION DATE: ______
☐ Saturation Biopsy Performed *(see reverse for biopsy requirements)*
PSA†: ______ ng/ml Date: ______ DRE†: ☐ Normal ☐ Abnormal
†PSA & DRE required for ConfirmMDx and for UroPredict® staging report
Previous Biopsy: ☐ None ☐ Benign ☐ Suspicious/ASAP ☐ HGPIN ☐ Malignant
Previous Therapy: ☐ Hormonal ☐ Surgery ☐ Radiation ☐ Chemotherapy ☐ Cryosurgery ☐ HIFU ☐ Other ______

Clinical information required for Genomic testing:
Pre-Biopsy PSA (ng/mL) ______
Prior Radiation or Hormone Therapy: ☐ No ☐ Yes ***(patient ineligible for testing)***
Clinical Stage: ☐ T1a ☐ T1b ☐ T1c ☐ T2a ☐ T2b ☐ T2c ☐ T3a ☐ T3b ☐ T4
Prostate Volume ______
Please include any medical notes: ______
Pre Treatment Recommendation (Radical Prostatectomy / External Beam Radiation / Brachytherapy / Active Surveillance / Other: (specify)): ______

TEST REQUESTED *(See reverse for test panel components)*

☐ **Prostate Histology**
Reflex Options: You may select up to two reflex options (one pos/one neg):
- ☐ ConfirmMDx on benign or HGPIN
- ☐ ProstaVysion on Gleason 6&7
- ☐ Decipher® Biopsy on Gleason 6&7
- ☐ Oncotype DX® GPS on Gleason 6&7*

For Gleason 6 or 3+4=7 and 4+3 w/only 1 positive core

☐ **Bostwick Blueprint for Prostate** (Histology w/ reflex ProstaVysion GS 6&7 ConfirmMDx on benign or HGPIN)

☐ **Bladder Histology**
- ☐ BladderVysion
- ☐ Rule Out IC (Interstitial Cystitis)

☐ **Vas Deferens Histology**

☐ **Other:** ______

PROGNOSTIC MARKERS
☐ MIB-1/Ki-67 ☐ Bcl-2

PANELS performed on previously diagnosed histology cases)
- ☐ ConfirmMDx on benign or HGPIN
- ☐ ProstaVysion on Gleason 6&7
- ☐ BladderVysion
- ☐ Decipher® Biopsy on Gleason 6&7
- ☐ Oncotype DX® GPS on Gleason 6&7*

For Gleason 6 or 3+4=7 and 4+3 w/only 1 positive core

Previous Histology Case Accession Number: *(example: BL16-0105-9999999)* ______

Note: Pathologist may order stains or additional tests when required for diagnosis. Reflex testing and additional stains will incur additional charges.

CYTOLOGY

ICD CODE: ______
COLLECTION DATE: ______ Collection Time: ______ ☐AM ☐PM

Specimen Type
☐ First Morning Void
☐ Catheterized Urine
☐ Bladder Wash
☐ Renal Wash: ☐ *Left* ☐ *Right*
☐ Post Cystoscopy Void
☐ Random Void
☐ Ileal Conduit/Neobladder
☐ Other: ______

Cystoscopy
☐ Normal ☐ Abnormal

Relevant History
☐ Bladder Ca ☐ CIS
☐ Diabetes ☐ Hypertension
☐ Renal Transplant ☐ Hematuria
☐ Other: ______

Previous Therapy
☐ BCG ☐ Radiation
☐ TURB ☐ Chemotherapy
☐ Other: ______

Previous Cytology
Date: ______
Dx: ☐ None ☐ Neg. ☐ Atypia ☐ Malignant

TEST REQUESTED
(See reverse for test panel components)

Please select the appropriate cytology test from the menu below. FISH options must be checked to be performed.

Note: Reflex tests are performed on atypical or suspicious diagnoses.

Cytology, MicroVysion and FISH Options	Reflex FISH Options	FISH Options
☐ Cytology	☐ With reflex FISH	☐ With FISH
☐ Cytology with Telomerase	☐ With reflex FISH	☐ With FISH
☐ CytologyPro *(Cytology with acid hematoxylin (AH) or Feulgen stain)*	☐ With reflex FISH	☐ With FISH
☐ CytologyPro XT *(Cytology, with Acid Hematoxylin (AH) or Feulgen, and telomerase stain)*	☐ With reflex FISH	☐ With FISH
☐ 3-Day Cytology	☐ With reflex FISH	☐ With FISH
☐ 3-Day Cytology with Telomerase	☐ With reflex FISH	☐ With FISH
☐ 3-Day CytologyPro *(Cytology with acid hematoxylin (AH) or Feulgen stain)*	☐ With reflex FISH	☐ With FISH
☐ 3-Day CytologyPro XT *(Cytology, with Acid Hematoxylin (AH) or Feulgen, and telomerase stain)*	☐ With reflex FISH	☐ With FISH
☐ MicroVysion	☐ With reflex FISH	☐ With FISH
☐ MicroVysion XT	☐ With reflex FISH	☐ With FISH
☐ FISH	☐ Other ______	

Note: MicroVysion is not performed on washings or ileal conduit. Pathologist may order stains or additional tests when required for diagnosis. Reflex testing and additional stains will incur additional charges.

BU160000000 LEFT LATERAL BASE PATIENT NAME	BU160000000 LEFT BASE PATIENT NAME	BU160000000 RIGHT BASE PATIENT NAME	BU160000000 RIGHT LATERAL BASE PATIENT NAME	BU160000000 CENTRAL BASE PATIENT NAME
BU160000000 LEFT LATERAL MID PATIENT NAME	BU160000000 LEFT MID PATIENT NAME	BU160000000 RIGHT MID PATIENT NAME	BU160000000 RIGHT LATERAL MID PATIENT NAME	BU160000000 CENTRAL MID PATIENT NAME
BU160000000 LEFT LATERAL APEX PATIENT NAME	BU160000000 LEFT APEX PATIENT NAME	BU160000000 RIGHT APEX PATIENT NAME	BU160000000 RIGHT LATERAL APEX PATIENT NAME	BU160000000 CENTRAL APEX PATIENT NAME
BU160000000 LEFT SEMINAL VESICLE PATIENT NAME	BU160000000 LEFT PATIENT NAME	BU160000000 RIGHT PATIENT NAME	BTP160001 RIGHT SEMINAL VESICLE PATIENT NAME	BU160000000 SITE ______ PATIENT NAME
BU160000000 MICROVYSION PATIENT NAME	BU160000000 CYTO./CYTOLOGY PRO/XT/FISH PATIENT NAME	BU160000000 PCA3PLUS PATIENT NAME	BU160000000 PROSTA~SEQ PATIENT NAME	BU160000000 SITE ______ PATIENT NAME

MEDICAL NECESSITY INFORMATION

It is our policy to provide health care providers with the ability to order only those lab tests medically necessary for the individual patient and to ensure that the convenience of ordering standard panels and custom profiles does not impact this ability. While we recognize the value of this convenience, indiscriminate use of panels and profiles can lead to ordering tests that are not medically necessary. Therefore, all tests offered in our panels and profiles can be ordered individually. If a component of a test is not listed individually on the request form, it may be written on the line labeled “OTHER” within that test section. We encourage you to order individual tests or a less inclusive profile when not all of the tests included in the panel or profile are medically necessary for the individual patient.

Test Panels Offered by Bostwick Laboratories	
BladderVysion™	**MicroVysion®**
FGFR3 Stain	Automated Chemistry w/o scope-Urine
Ki-67 Stain	Beta-2 Microglobulin-Urine
p53 Stain	Cytology, Liquid Base
PTEN FISH	Acid Hematoxylin or Feulgen stain
	Microalbumin, Quantitative-Urine
CytologyPro™	Creatinine-Urine
Cytology	Protein-Urine
Acid Hematoxylin or Feulgen Stain	**MicroVysion XT**
	The components listed above plus Telomerase (Anti-h TERT) Stain
CytologyPro XT™	
Cytology	**ProstaVysion™**
Acid Hematoxylin or Feulgen Stain	ERG Stain
Telomerase (Anti-h TERT) Stain	PTEN FISH

Saturation Biopsy Requirements
Patient insurance pre-authorization or appropriate clinical history documenting clinical necessity is required for saturation biopsy cases.

Explanation of Reflex Test Offerings

Below are the description of the test panels and shown on the front of the requisition. By requesting any of the below test panels on the requisition, you are acknowledging that all components of the panel are medically necessary for the diagnosis and treatment of the patient.

Explanation of Prostate Histology Reflex Order Options
(See test panel components below)

» **ProstaVysion on Gleason 6&7:** Prostate histology will reflex to ProstaVysion with a Gleason 6 or 7 diagnosis

» **ConfirmMDx on benign or HGPIN:** Prostate histology will reflex to ConfirmMDx on a benign or HGPIN diagnosis (Not performed on ASAP).

» ***Genomic Health® Oncotype DX® Genomic Prostate Score:** Prostate histology will reflex to Oncotype DX® GPS with a Gleason 6 (3+3) or 7 (3+4 or 4+3 w/ only 1 positive core) diagnosis.

» **Decipher Biopsy on Gleason 6&7:** Prostate histology will reflex to Decipher Biopsy with a Gleason 6 or 7 diagnosis.

Explanation of Bladder Histology Reflex Order Options
(See test panel components below)

» **BladderVysion on positive:** Bladder histology will reflex to BladderVysion on malignant cases.

Explanation of Urine Cytology Reflex Order Options
(See test panel components below)

» **Cytology w/reflex FISH:** Cytology will reflex to fluorescence in situ hybridization (FISH) on an atypical/suspicious diagnosis.

» **Cytology w/FISH:** FISH will be performed with Cytology regardless of diagnosis.

» **Cytology with Telomerase with reflex FISH:** Cytology with Telomerase will reflex to FISH on atypical/suspicious diagnosis.

MEDICAL NECESSITY ATTESTATION

***Genomic Health® Oncotype DX® Genomic Prostate Score**

Your signature constitutes a Statement of Medical Necessity (SOMN) and your attestation of the following: 1) accurate clinical information has been entered above, as this will be used by GHI to automatically calculate the patient’s risk group (as indicated in NCCN 2016 v.3) and inaccurate information could impact the test result; 2) if the diagnosis or exception criteria sections of the form do not indicate otherwise, the patient meets the assay criteria; 3) the test is medically necessary and test results will be used with other clinical data to help determine the appropriate treatment plan for the patient; 4) the patient has consented for this test to be performed, and for Genomic Health Inc. to release test information when necessary to obtain reimbursement.

For Medicare Beneficiaries: You further certify that you have completed requisite training and have enrolled in the Genomic Health CTR Program and that the patient meets the Medicare patient eligibility criteria provided on the requisition form instructions.

Explanation of Urine Cytology Reflex Order Options (cont.)
(See test panel components below)

» **Cytology with Telomerase with FISH:** FISH will be performed with Cytology with Telomerase regardless of diagnosis.

» **CytologyPro reflex FISH:** CytologyPro XT will reflex to FISH on atypical/suspicious diagnosis.

» **CytologyPro w/FISH:** FISH will be performed with CytologyPro regardless of diagnosis.

» **CytologyPro XT reflex FISH:** CytologyPro XT will reflex to FISH on atypical/suspicious diagnosis.

» **CytologyPro XT w/FISH:** FISH will be performed with CytologyPro XT regardless of diagnosis.

» **3-Day Cytology:** Cytology tests will be performed over three consecutive days.

» **3-Day Cytology w/reflexFISH:** 3-Day Cytology will reflex to FISH on an atypical/suspicious diagnosis. FISH will be performed on only one of the three cytology specimens.

» **3-Day Cytology w/FISH:** FISH will be performed with 3-Day Cytology regardless of diagnosis. FISH will be performed on only one of the three cytology specimens.

» **3-Day CytologyPro:** CytologyPro tests will be performed over three consecutive days.

» **3-Day CytologyPro w/reflex FISH:** FISH will be performed with 3-Day CytologyPro on an atypical or suspicious diagnosis. FISH will be performed on only one of the three cytology specimens.

» **3-Day CytologyPro w/FISH:** FISH will be performed with 3-Day CytologyPro regardless of diagnosis. FISH will be performed on only one of the three cytology specimens.

» **3-Day CytologyPro XT w/reflex FISH:** FISH will be performed with 3-Day CytologyPro XT on an atypical or suspicious diagnosis. FISH will be performed on only one of the three cytology specimens.

» **3-Day CytologyPro XT w/FISH:** FISH will be performed with 3-Day CytologyPro XT regardless of diagnosis. FISH will be performed on only one of the three cytology specimens.

» **MicroVysion with reflex FISH:** MicroVysion will reflex to FISH on an atypical/suspicious diagnosis.

» **MicroVysion with/FISH:** FISH will be performed with MicroVysion regardless of diagnosis.

» **MicroVysion XT with reflex FISH:** MicroVysion XT will reflex to FISH on an atypical/suspicious diagnosis.

» **MicroVysion XT with/FISH:** FISH will be performed with MicroVysion XT regardless of diagnosis.