CASTLE BIOSCIENCES

DecisionDx Melanoma

Customer service: **866-788-9007**
Email: **clinicalservices@castlebiosciences.com**

Fax toll free: **866-329-2224**
Alternate fax: **602-222-5200**

I. Ordering entity information

Provider name*	Specialty	NPI	Institution/Practice name*
Address*		City / state / zip*	
Office contact name*	Phone*	Fax*	Email

II. Patient information

Name (last, first, MI)*	DOB*	Gender	SSN / MR#
Address*	City / state / zip*		
Phone*	Email		

III. Billing information

Submitting diagnosis / ICD-10 code*
Please select code from dropdown list

Payment method ☐ Private insurance ☐ Patient self-pay ☐ Medicare ☐ Medicaid
☐ Client bill *(contracted entities only)* Secondary insurance? ☐ Yes ☐ No *(If yes, attach copy of card)*

Insurance name	Policy #*	Insurance phone

IV. Test menu*

Primary test:
☐ DecisionDx-Melanoma Gene Expression Profile

Additional testing desired: (3-gene NGS test for somatic mutations)
☐ DecisionDx-CMSeq sequencing test *(BRAF, NRAS, KIT)*

DecisionDx-CMSeq *is a 3-gene test that uses next-generation sequencing (NGS) to identify somatic mutations relevant to cutaneous melanoma in melanoma tumor tissue. The test includes hotspot mutations in the genes BRAF, NRAS and KIT.*

V. Facility information *(Required for ALL patients)**

At time of tissue collection, was this patient: ☐ Non-hospital ☐ Hospital outpatient ☐ Hospital inpatient If hospital inpatient, discharge date: _____

If specimen is stored **for more than 30 days** from the date of collection, please provide the date specimen is pulled from archive: _____

VI. Clinical information

Has the patient had a sentinel lymph node biopsy for *this* melanoma? ☐ N ☐ Y	Tumor site:	If yes, what was the result? ☐ Neg ☐ Pos (if positive please provide surg report)
Does / Did this patient have clinically palpable nodes? ☐ N ☐ Y	Does / Did this patient have intransit metastasis: ☐ N ☐ Y	

VII. Required signature

I am concerned this patient's tumor biology may differ significantly from its histopathologic profile (ie: may have inadequate microstaging). My signature below confirms this test to be medically necessary for this patient. I provide consultation and/or treatment for melanoma and will use the results in the management of the patient.

Signature of treating clinician*	Printed name	Date

VIII. Treating clinician

Provider name *(if different than section I)*	Phone	Fax	Institution / Practice name
Address (☐ same as requestor)	City / state / zip		

Additional name *(optional)*	Phone	Fax	Institution / Practice name
Address (☐ same as requestor)	City / state / zip		

IX. Laboratory contact information

Facility where tissue is maintained	Collection date
Phone	Fax

Please fax this requisition along with a copy of the pathology report from the primary biopsy and excision (if available)

For internal use only		
Received	Processed by	Materials received
PR / Initials	DTL	Note

* Required item

SECTION I. Complete with information of the ordering entity.

SECTION II. Complete with patient information.

SECTION III. Provide the ICD-10 code and patient's diagnosis. Select method of payment. Please complete with billing information including a copy of the front and back of the insurance card (if applicable). If the person completing this requisition is not in possession of the information necessary for completion of the billing information section, please provide the name/department and contact information of the appropriate party from whom this information can be obtained.

Name: _____ Department: _____
Phone: _____ Fax: _____

**If a copy of the front and back of the insurance card is provided, no further information is needed in this section of the requisition. A billing face sheet is also sufficient in lieu of copy of card.*

SECTION IV. Select the desired test by checking the appropriate box. Select the desired testing service by checking on Gene Expression profile alone, DecisonDx-CM*Seq* NGS panel alone, or both tests concurrently.

SECTION V. Complete information for patient.

SECTION VI. Check the appropriate box regarding the patient's current sentinel lymph node biopsy status for this melanoma. If the patient has had a SLNB performed, please provide a copy of the surgical path report along with the completed requisition. Please provide information regarding presence of palpable node(s) and/or intransit metastasis.

SECTION VII. The ordering clinician must sign this section. **Note:** For purposes of ordering this test, the "ordering clinician" section can be signed only by a physician, advanced practice registered nurse (APRN) or representative physician assistant (PA).

SECTION VIII. Complete with information for the treating clinician and/or additional clinicians. If the mailing address is the same as for the ordering clinician, check the box "same as requestor". Be sure to select the preferred method by which results should be communicated and provide an email address if you wish to receive electronic notification that the report is available.

SECTION IX. Complete this section with the name of the facility where the tissue from which slides for testing will be requested.

Contact customer service: **866-788-9007**
Fax the following documents toll free: **866-329-2224**
or email **reqs@castlebiosciences.com** (Alternate fax: **602-222-5200**).
If you are interested in online ordering, please contact us at
clinicalservices@castlebiosciences.com

☐ Completed requisition
☐ Pathology report(s)

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