INVITAE detect

ORDER ID For Invitae internal use only	**Requisition Form** Invitae Detect Hereditary Pancreatic Cancer Program TRF959-1

This requisition form can be used to submit a specimen for the Invitae Detect Hereditary Pancreatic Cancer program, a complimentary testing program for individuals diagnosed with pancreatic cancer. Please confirm that the patient meets the eligibility requirements for the program. To submit orders for genetic testing outside of this program, please order through Invitae's online portal or use a standard requisition form: www.invitae.com/order-forms.

REQUIRED PROGRAM ELIGIBILITY

This program is available to individuals in the U.S. and Canada with (please check one):

- ☐ Pancreatic adenocarcinoma at any age
- ☐ Pancreatic neuroendocrine tumor at any age

PATIENT INFORMATION

First name	MI	Last name
Date of birth (MM/DD/YYYY)	Biological sex ◯ M ◯ F	MRN (medical record number)

Ancestry ◯ Asian ◯ Black/African American ◯ White/Caucasian ◯ Ashkenazi Jewish ◯ Hispanic ◯ Native American ◯ Pacific Islander ◯ French Canadian ◯ Sephardic Jewish ◯ Mediterranean ◯ Other: _____

Phone	Email address
Address	City
State	Zip code / Country

SPECIMEN INFORMATION

Label each tube with the patient's full name, date of birth, and specimen collection date.
A requisition form MUST accompany each specimen. www.invitae.com/specimen-requirements

Specimen type : ◯ Blood ◯ Saliva ◯ Assisted saliva

We are unable to accept blood/saliva from patients with:

- *Allogeneic bone marrow transplants*
- *Blood transfusion <2 weeks prior to specimen collection*

Collection date (MM/DD/YYYY) *If not provided, date will be 1 day prior to our receipt of specimen.*

Special cases : ◯ History of/current hematologic malignancy

ORGANIZATION INFORMATION

Organization name and address

Organization name	
Phone	Fax
Address	City
State / Zip code	Country

Primary clinical contact

Name	Role/title
Phone	NPI
Email address (for report access)	

Ordering physician

◯ **Same as primary clinical contact**

Name	NPI
Email address (for report access)	

Additional clinical or laboratory contact (optional)

Name	Email address (for report access)

REQUIRED INVITAE DETECT HEREDITARY PANCREATIC CANCER CLINICAL INFORMATION

Required clinical history (select the stage that best fits your patient's current stage)

- ☐ **0**
- ☐ **IA / IB**
- ☐ **IIA / IIB**
- ☐ **III**
- ☐ **IV**
- ☐ **Unknown**

INVITAE PARTNER CODE	PAN

To request a complimentary specimen collection kit, visit www.invitae.com/request-a-kit.

SHIPPING INSTRUCTIONS

Please ship specimen to Invitae:

Attn: Invitae Client Services
1400 16th Street
San Francisco, CA 94103 USA

OPTIONAL CLINICAL HISTORY (useful for clinical trial matching)

Prior or current treatments (select all that apply)

Chemotherapy

- ☐ Platinum-based (cisplatin, carboplatin, or oxaliplatin)
- ☐ Cytotoxic chemotherapy
- ☐ Other_____

- ☐ **PARPi**
- ☐ **Surgical intervention**
- ☐ **N/A**

ECOG performance score: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

OPTIONAL FAMILY HISTORY

Is there a family history of cancer? ☐ Yes ☐ No ☐ Unknown

If yes, describe below and attach pedigree and/or clinical notes.

Relationship to patient	Maternal or paternal	Cancer diagnosis	Age at diagnosis

TEST OPTIONS

Invitae continually updates its panels based on the most recent evidence. If an order is placed using an older version of this form, Invitae reserves the right to upgrade any ordered panel(s) to the current version(s). Test IDs containing add-on codes will include the original panel as well as the add-on.

All orders submitted through the Detect Hereditary Pancreatic Cancer program will include analysis of the following panels at minimum:

- **Invitae BRCA1 and BRCA2 STAT Panel (Report 1)**
- **Invitae Multi-Cancer Panel with add-on pancreatic cancer preliminary evidence genes (Report 2)**

Clinicians will receive two reports. Results of the Invitae BRCA1 and BRCA2 STAT Panel will be reported within 5-12 calendar days from sample accessioning. Results of the Invitae Multi-Cancer Panel with add-on pancreatic cancer preliminary evidence genes will be reported separately within 21 days of delivery of report 1.

TESTS INCLUDED IN THE PROGRAM

Test code	Test name	# of genes	Gene list
SPECIAL INSTRUCTIONS FOR STAT PANEL: **Only blood and saliva are accepted (DNA is not accepted)**			
◉ 50002	Invitae BRCA1 and BRCA2 STAT Panel	2	BRCA1, BRCA2

REQUIRED REFLEX (results will be included in report 2)

◉ 01101	Invitae Multi-Cancer Panel ▶ Reflex to this panel ◉ Regardless of initial results ○ Only if negative (no pathogenic/likely pathogenic results)	84	AIP, ALK, APC, ATM, AXIN2, BAP1, BARD1, BLM, BMPR1A, BRCA1, BRCA2, BRIP1, CASR, CDC73, CDH1, CDK4, CDKN1B, CDKN1C, CDKN2A, CEBPA, CHEK2, CTNNA1, DICER1, DIS3L2, EGFR, EPCAM, FH, FLCN, GATA2, GPC3, GREM1, HOXB13, HRAS, KIT, MAX, MEN1, MET, MITF, MLH1, MSH2, MSH3, MSH6, MUTYH, NBN, NF1, NF2, NTHL1, PALB2, PDGFRA, PHOX2B, PMS2, POLD1, POLE, POT1, PRKAR1A, PTCH1, PTEN, RAD50, RAD51C, RAD51D, RB1, RECQL4, RET, RUNX1, SDHA, SDHAF2, SDHB, SDHC, SDHD, SMAD4, SMARCA4, SMARCB1, SMARCE1, STK11, SUFU, TERC, TERT, TMEM127, TP53, TSC1, TSC2, VHL, WRN, WT1
◉ 01261.1	Add-on pancreatic cancer preliminary-evidence genes	3	CDK4, FANCC, PALLD

OPTIONAL ADD-ON GENES (results will be included in report 2)

○ 01261.2	Add-on chronic pancreatitis genes	5	CASR, CFTR, CTRC, PRSS1, SPINK1

By signing this form, the medical professional acknowledges that the individual/family member authorized to make decisions for the individual (collectively, the "Patient") has been supplied information regarding and consented to undergo genetic testing, substantially as set forth in Invitae's Informed Consent for Genetic Testing (www.invitae.com/patient-consent). In connection with the Program the Patient has been informed that Invitae may notify them of clinical updates related to genetic test results (in consultation with the ordering medical professional as indicated) and has been informed that de-identified Patient data may be used and shared with third parties, for research and commercial purposes and, in the U.S., to contact their medical professional. For orders originating in Canada, the Patient has been informed that their personal information and specimen will be transferred to and processed in the U.S. and that de-identified Patient data may be used and shared for research and commercial purposes in the U.S. The medical professional warrants that he/she will not seek reimbursement for this no-charge test from any third party, including but not limited to federal healthcare programs. The medical professional also hereby acknowledges that organization and clinician contact information provided in the order may be shared with third parties, including commercial organizations, that may contact the medical professional directly in connection with the Program, and that they have made the Patient aware that de-identified Patient data may be used and shared with such third parties, for purposes which include contacting their medical professional directly in connection with the Program. A list of third party partners may be provided upon request. In addition to the above, I attest that I am the ordering physician, or I am authorized by the ordering physician to order this test, or I am authorized under applicable state law to order this test.

Medical professional signature (required)	Date