INVITAE

If an order is placed using an outdated test requisition form, Invitae reserves the right to upgrade ordered tests to the current versions. View current requisition forms at www.invitae.com/forms.

ORDER ID
For Invitae internal use only

INVITAE PGT REQUISITION FORM

PATIENT INFORMATION

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

Email address (for patient pay billing)	Mobile phone (for billing contact)	Ancestry: ◯ Asian ◯ Black/African American ◯ White/Caucasian ◯ Ashkenazi Jewish ◯ Hispanic ◯ Native American ◯ Pacific Islander ◯ French Canadian ◯ Sephardic Jewish ◯ Other: _____

Address	City	State/Prov	Zip/Postal code	Country

CLINICIAN INFORMATION

Organization name	Phone	Fax

Address	City	State/Prov	Zip/Postal code	Country

Primary clinical contact name (if different from ordering provider)	NPI	Email address (for report access)

Ordering provider (Pre-populate your provider list below. For each order, indicate **one** ordering provider by marking the checkbox before the name)

	Name	NPI	Email address (for report access)		Name	NPI	Email address (for report access)
◯				◯			
◯				◯			
◯				◯			

Additional clinical or laboratory contacts (optional) ◯ Share this order with the primary clinical contact's default clinical team (manage team online at www.invitae.com/signin)

Name	Email address (for report access)	Name	Email address (for report access)

PREIMPLANTATION GENETIC TESTING (PGT)

PGT-A (aneuploidy) *Identifies embryos with the correct number of chromosomes.*

◯ PGT for aneuploidy (PGT-A) **WITH** sex reported ◯ PGT for aneuploidy (PGT-A) **WITHOUT** sex reported

PGT-SR (structural rearrangements) *Evaluates embryos for unbalanced chromosome rearrangements from a known translocation carrier. This test also screens for aneuploidy. If ordering PGT-SR, please select "Known structural chromosomal rearrangement" under reason for testing and submit the PGT-SR Referral Form. Once Invitae receives this form and required karyotypes, our medical team will determine within 1 to 2 business days whether your patient is a candidate for PGT-SR.*

◯ PGT for structural rearrangements/translocations (PGT-SR) **WITH** sex reported ◯ PGT for structural rearrangements/translocations (PGT-SR) **WITHOUT** sex reported

Specimen type: Trophectoderm (blastocyst) biopsy *(embryos must be frozen after biopsy, Invitae cannot accommodate fresh transfers)*

Was ICSI performed? ◯ Yes ◯ No *(Note: Samples derived from non-ICSI embryos may have an increased risk for false negative or false positive results.)*

Does this case include a re-biopsy of previously tested embryo(s)? ◯ Yes ◯ No If yes, please provide the original Order ID: PAT# _____

Partner information: Partner's biological sex: ◯ Male ◯ Female Partner's MRN: _____

Partner's first name: _____ Partner's last name: _____ Partner's DOB (MM/DD/YYYY): ____ / ____ / ____

Donor information: Egg donor cycle? ◯ Yes ◯ No Age of donor: _____ Sperm donor cycle? ◯ Yes ◯ No Age of donor: _____

Reason for testing (select all that apply):

- ◯ Advanced maternal age
- ◯ Repeat failed implantation/failed IVF cycles: number of failed cycles: _____
- ◯ Recurrent pregnancy loss: number of losses: _____
- ◯ Known structural chromosomal rearrangement (Please submit a copy of the PGT-SR Referral Form [available at www.invitae.com/forms] for clinical review prior to placing an order for structural chromosome rearrangements from known translocation carriers.)
- ◯ Routine aneuploidy screening/patient request
- ◯ Family balancing → MALE/FEMALE
- ◯ Male infertility
- ◯ Other: _____

Billing selection (select one):

- ◯ Patient pay - *Note: Patient's email is required above to enable electronic payment.*
- ◯ Institutional
- ◯ Loan provider - Company name: _____ Primary member ID # _____ Company phone: _____ Prior Auth #: _____
- ◯ Insurance - *Note: Insurance coverage for PGT is limited to certain participating plans, call Invitae Billing at 800-436-3037 to confirm plan participation.*

Policyholder name: _____ Patient relationship to policyholder: ◯ Self ◯ Spouse ◯ Child ◯ Other: _____

Company name: _____ Primary member ID #: _____ Company phone: _____ Prior Auth #: _____

ICD-10 code(s): ◯ N97.9 Female infertility, unspecified ◯ N46.9 Male infertility, unspecified ◯ Other ICD-10 code(s): _____

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/forms). For orders originating outside the US, the Patient has been informed their personal information and specimen will be transferred to and processed in the US. If insurance billing is selected, the Patient has further been informed and authorizes Invitae Corporation ("Invitae") and its designees to release information concerning testing to their insurer in order to process and/or appeal claims. The medical professional agrees to allow Invitae to transfer the information from this requisition to a letter of medical necessity and/or other documentation using the medical professional's name as the signature. For amounts received directly, the Patient has agreed to remit payment to Invitae for testing services rendered. I acknowledge that the Patient has agreed that if the Patient's insurer does not reimburse Invitae in full for any reason, including if the insurer considers the genetic test ordered to be a non-covered service or not medically necessary, then Invitae may bill the Patient directly for the services and the Patient will remit payment directly to Invitae. I acknowledge that I offered pre-test genetic counseling to the Patient, if required by their insurer. I attest that I am authorized under applicable law to order this test.

Medical professional signature (required)	**Date (MM/DD/YYYY)**