INVITAE

ORDER ONLINE at www.invitae.com/signin.

ORDER ID
For Invitae internal use only

INVITAE REQUISITION FORM

PATIENT INFORMATION

First name | MI | Last name | Date of birth (MM/DD/YYYY)

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: _____

Email address (for report access after release by medical professional) | Phone

Address

City | State | ZIP code | Country

ORGANIZATION INFORMATION

Organization name and address

Organization name			Phone
Address			Fax
City	State	ZIP code	Country

Primary clinical contact

Name	NPI
Email address (for report access)	Phone

Ordering physician

○ **Same as primary clinical contact**

Name	NPI
Email address (for report access)	Phone

Additional clinical or laboratory contacts (optional)

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

○ INSURANCE BILLING (Please attach a copy of the patient's card.)

We do not accept insurance for certain tests *or* patients outside the US. Before completing this section, confirm your test is eligible at www.invitae.com/billing.

Primary insurance company name	Primary member ID#
Secondary insurance company name	Secondary member ID#
○ Patient has Medicare and was treated as a hospital inpatient (>24 hour stay) in the last 14 days.	Prior-authorization #

Letter of Medical Necessity (LMN)

○ I have attached an LMN and/or other documents for insurance billing purposes.

○ I agree to allow Invitae to transfer the information from this requisition to an LMN and/or other documentation using the ordering physician's name as the signature for insurance billing.

○ INSTITUTIONAL BILLING

Invitae will send an invoice to the organization address above.
Please contact Invitae if this order should be billed to a different location.

○ PATIENT PAY BILLING

Invitae will send an electronic invoice to the patient email listed above

○ OTHER BILLING

Invitae partner code:

INVITAE

Patient's first name

Patient's last name

INVITAE PGT REQUISITION FORM

SPECIMEN INFORMATION

The specimen type for this test is trophectoderm (blastocyst) biopsy. Embryos must be frozen after biopsy, as we cannot accommodate fresh transfers.

Was ICSI performed? ◯ Yes ◯ No

**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 PAT#_____

PARTNER AND DONOR INFORMATION

Partner's first name

Partner's last name

Partner's sex ◯ M ◯ F

Partner's DOB (MM/DD/YYYY)

Partner's MRN

Egg donor cycle? ◯ Yes ◯ No Age of donor: _____

Sperm donor cycle? ◯ Yes ◯ No Age: _____

REASON FOR TESTING

Please indicate the reason for testing by selecting all that apply:

◯ Advanced maternal age

◯ Repeat failed implantation/failed IVF cycles
# of failed cycles: _____

◯ Recurrent pregnancy loss
# 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:
Please specify:

_____

_____

TEST INFORMATION

PGT-A (aneuploidy, also known as PGS) identifies embryos with the correct number of chromosomes.

◯ Preimplantation genetic testing for aneuploidy (PGT-A) **WITH** sex reported

◯ Preimplantation genetic testing 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.

◯ Preimplantation genetic testing for structural rearrangements/translocations (PGT-SR) **WITH** sex reported

◯ Preimplantation genetic testing for structural rearrangements/translocations (PGT-SR) **WITHOUT** sex reported

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

SHIPPING INSTRUCTIONS
Please ship specimen overnight in insulated containers:

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

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/PGT-consent), and for orders originating outside the US, has been informed that the Patient's personal information and specimen will be transferred to and processed in the US. The Patient has further been informed and authorizes Invitae Corporation ("Invitae") and its designees to release information concerning testing to their insurer, if applicable, in order to process and/or appeal claims on behalf of the Patient. If a letter of medical necessity (LMN) has not been provided, the medical professional agrees to allow Invitae to transfer the information from this requisition to a LMN and/or other documentation using the medical professional's name as the signature for insurance billing. For amounts received directly, the Patient has agreed to remit payment to Invitae for testing services rendered. I acknowledge that I offered pre-test genetic counseling to the Patient, if required by their insurer. 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 law to order this test.

Medical professional signature	**Date**