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)

Biological sex
- ○ Male
- ○ Female

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)

Mobile phone

Address

City | State | ZIP code | Country

ORGANIZATION INFORMATION

Organization name			Phone	Fax	
Address	City	State/Prov	ZIP/Postal Code	Country	

CLINICAL TEAM

Primary clinical contact (contact for general inquires)

Name	NPI	Email address (for report access)

Ordering physician ○ Same as primary clinical contact

For your convenience, we have provided multiple fields below to pre-populate your organization's physician list. For each order, indicate one ordering physician.

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

Additional clinical or laboratory contacts (optional; share online access to this order with the contacts below)

○ Share this order with the primary clinical contact's default clinical team (establish and manage team online at www.invitae.com/signin)

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 (attach front and back of insurance card)

Attach clinical notes, medical records, and/or letter of medical necessity (LMN) to prevent delays. We do not accept insurance for certain tests *or* patients outside the US. www.invitae.com/billing

Policyholder name	Patient relationship to policyholder ○ Self ○ Spouse ○ Child ○ Other: ________		**ICD-10 code required** Indicate in REASON FOR TESTING section
Primary insurance company name	Primary member ID#	Primary insurance phone	Primary prior-authorization #
Secondary insurance company name	Secondary member ID#	Secondary insurance phone	Secondary prior-authorization #

○ PATIENT PAY BILLING

Invitae will send an electronic invoice to the patient email listed above. Insurance will not be billed.

○ 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.

○ PARTNERSHIP PROGRAMS

Invitae partner code:

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INVITAE

Patient's first name | Patient's last name

INVITAE NIPS + CARRIER REQUISITION FORM

NON-INVASIVE PRENATAL SCREENING (NIPS)

SPECIMEN INFORMATION

NIPS collection date (MM/DD/YYYY) *MUST be provided for order processing*

○ **Specimen type:** Blood (two 10 mL Streck tubes)

NIPS TEST INFORMATION

Invitae NIPS will be sent out by Invitae to Verinata Health, Inc, a wholly owned subsidiary of Illumina, Inc., which will then perform the screen and send the report to Invitae.

- ○ 71001 Invitae NIPS for singleton pregnancies (chromosomes 13, 18, 21)
  - ○ 71001.1 Add-on for sex chromosomes (will report predicted fetal sex)
  - ○ 71001.2 Add-on for microdeletions (1p36, 4p16.3, 5p15.2, 15q11.2, 22q11.2)
- ○ 71002 Invitae NIPS for twin pregnancies (chromosomes 13, 18, 21)
  - ○ 71002.1 Add-on for presence of Y chromosome (to infer predicted fetal sex)

REASON FOR TESTING

Patient's estimated due date (MM/DD/YYYY):

Select all reasons for testing that apply:

- ○ Advanced maternal age (>35 years)
- ○ Positive serum screen: ______
- ○ Abnormal ultrasound: ______
- ○ History suggestive of increased risk: ______
- ○ Average risk pregnancy
- ○ Other: ______

ICD-10 codes

Code	Description	Code	Description
○ O09.519	Advanced maternal age (1st pregnancy)	○ O35.0XX0	Maternal care for (suspected) central nervous system malformation in fetus
○ O09.529	Advanced maternal age (subsequent pregnancy)	○ O35.1XX0	Maternal care for (suspected) chromosomal abnormality in fetus
○ O09.299	Pregnancy with other poor reproductive or obstetric history	○ O35.2XX0	Maternal care for (suspected) hereditary disease in fetus
○ O28.3	Abnormal ultrasonic finding on an antenatal screening of mother	○ Q95.9	Balanced rearrangement and structural marker
○ O28.9	Abnormal finding, unspecified, on an antenatal screening of mother	○ Other	

CARRIER SCREENING

SPECIMEN INFORMATION

Carrier screening collection date (MM/DD/YYYY)

If not provided, date will be 1 day prior to our receipt of specimen.

Specimen type: ○ Blood (one 6 mL EDTA tube) ○ Saliva

REPRODUCTIVE PARTNER INFORMATION (OPTIONAL)

Has Invitae carrier screening already been ordered for this individual's reproductive partner? ○ No ○ Yes

After carrier screening is ordered for a patient, their partner becomes eligible for $100 self-pay pricing. There is no need to wait for the first patient's result before ordering reduced-price testing for the partner - in this case, select 'yes' for only one of the patients.

Partner's first name	Partner's last name
Partner's requisition ID:	Partner's DOB (MM/DD/YYYY):

REASON FOR TESTING

Select all reasons for testing that apply:

- ○ Screening (no family history)
- ○ Patient/partner is pregnant. Estimated due date (MM/DD/YYYY): ______
- ○ Gamete donor
- ○ Family history. Specify disorder(s) and relationship(s): ______
- ○ Patient's partner is a known carrier. Specify disorder(s): ______
- ○ Other: ______

ICD-10 codes

Code	Description	Code	Description
○ Z31.430	Female screening for carrier status for procreative management	○ Z15.89	Genetic susceptibility to disease/high-risk ethnicity
○ Z31.440	Male screening for carrier status for procreative management	○ Z84.81	Family history of carrier of genetic disease
○ Z13.17	Nonprocreative screening for genetic disease carrier status	○ Z81.0	Family history of intellectual disabilities
○ Z34.90	Supervision of normal pregnancy	○ N97.9	Female infertility
○ O09.00	Supervision of pregnancy with history of infertility	○ N46.9	Male infertility
○ O35.2XX0	Maternal care for suspected hereditary disease in fetus	○ Other	

CARRIER SCREENING TEST INFORMATION

COMPREHENSIVE CARRIER SCREENS	# gene(s)
○ 60100 Invitae Comprehensive Carrier Screen	288
○ 60200 Invitae Comprehensive Carrier Screen without X-Linked Disorders	267
BROAD CARRIER SCREENS	**# gene(s)**
○ 60101 Invitae Broad Carrier Screen	46
○ 60201 Invitae Broad Carrier Screen without X-Linked Disorders	41

CUSTOM PANEL ID

Invitae supports customization of your test. To create a custom panel, log in to your Invitae portal account or contact Client Services. Then indicate the ID associated with that panel here.

Custom panel ID

CORE CARRIER SCREEN	# gene(s)	CORE CARRIER SCREEN WITHOUT X-LINKED DISORDERS	# gene(s)
○ 60102 Invitae Core Carrier Screen (CF, SMA, fragile X)	3	○ 60104 Invitae Core Carrier Screen without X-Linked Disorders (CF, SMA)	2
○ 60102.1 Add-on alpha-thalassemia genes	2	○ 60104.1 Add-on alpha-thalassemia genes	2
○ 60102.2 Add-on HBB-related hemoglobinopathies gene	1	○ 60104.2 Add-on HBB-related hemoglobinopathies gene	1

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/nips-carrier-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 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 NIPS test 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. 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**

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