



If an order is placed using an older version of this form, Invitae reserves the right to upgrade ordered tests to the current versions. View current requisition forms at www.invitae.com/forms. Please note: Test IDs containing add-on codes will include the original panel as well as the add-on.

ORDER ID
For Invitae internal use only

**INVITAE OB-GYN
REQUISITION FORM**

PATIENT INFORMATION

First name	MI	Last name	Date of birth (MM/DD/YYYY)	Biological sex <input type="radio"/> Male <input type="radio"/> Female	MRN (medical record number)
Email address (billing and report access after clinician releases)		Mobile phone (for billing contact)	Ancestry: <input type="radio"/> Asian <input type="radio"/> Black/African American <input type="radio"/> White/Caucasian <input type="radio"/> Ashkenazi Jewish <input type="radio"/> Hispanic <input type="radio"/> Native American <input type="radio"/> Pacific Islander <input type="radio"/> French Canadian <input type="radio"/> Sephardic Jewish <input type="radio"/> Other: _____		
Address		City	State/Prov	Zip/Postal code	Country
INSURANCE INFORMATION (Provide only if applicable. Attach front and back of insurance card, clinical notes and medical records. Insurance is not accepted for patients outside the US.)					
Policyholder name		Primary insurance company name	Primary member ID #	Primary insurance phone	Prior-authorization #
Patient relationship to policyholder <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other: _____		Secondary insurance company name	Secondary member ID #	Secondary insurance phone	Prior-authorization #

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 <u>one</u> ordering provider by marking the checkbox before the name)							
<input type="checkbox"/>	Name	NPI	Email address (for report access)	<input type="checkbox"/>	Name	NPI	Email address (for report access)
<input type="checkbox"/>	_____	_____	_____	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/>	_____	_____	_____	<input type="checkbox"/>	_____	_____	_____
Additional clinical or laboratory contacts (optional) <input type="checkbox"/> 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)	

CARRIER SCREENING

INVITAE PANELS

60100 Invitae Comprehensive Carrier Screen (288 genes)
 60100.1 Add-on genes with variable presentation (13 genes)

60101 Invitae Broad Carrier Screen (46 genes)
 60102 Invitae Core Carrier Screen - CF, SMA, fragile X (3 genes)
 60104 Invitae Core Carrier Screen without X-Linked Disorders - CF, SMA (2 genes)

CUSTOM PANEL ID

_____ Provide eight character ID. To create a custom panel ID, log in to your Invitae portal or contact Client Services

Specimen type: Blood (6-mL purple EDTA tube) -OR- Saliva (Oragene™ kit)

Carrier collection date (MM/DD/YYYY): _____
If not provided, the day before specimen receipt will be used

Reason for testing (select all that apply):
 Screening (no family history) Gamete donor Other: _____
 Family history. Specify disorder(s) and relationship: _____
 Patient's partner is a known carrier. Specify disorder(s): _____
 Patient/partner is pregnant. Estimated due date (MM/DD/YYYY): ____ / ____ / ____

Has Invitae carrier screening already been ordered for this individual's reproductive partner?
After the initial test is ordered, the patient's partner is eligible for \$100 patient pay pricing (select 'yes' for only one patient)
 No Yes: Partner Name/Invitae RQ: _____ DOB: ____ / ____ / ____

Billing selection (select one):
 Patient pay
 Institutional
 Insurance (ICD-10 code(s) below required):
 Z31.430 Female carrier screening Z84.81 Family history of carrier status
 Z31.440 Male carrier screening Z15.89 Genetic susceptibility to disease
 Z34.90 Supervision of normal pregnancy Other ICD-10: _____

NON-INVASIVE PRENATAL SCREENING (NIPS)

SINGLETON PREGNANCIES

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)

TWIN PREGNANCIES

71002 Invitae NIPS for twin pregnancies (chromosomes 13, 18, 21)
 71002.1 Add-on for presence of Y chromosome (to infer predicted fetal sex)

Specimen Type: Blood (10-mL black and tan Streck Cell-Free DNA tubes, 2 tubes)

NIPS collection date (MM/DD/YYYY): _____

Patient's estimated due date: _____
Required: minimum 10 weeks gestational age

Reason for testing (select all that apply):
 Advanced maternal age (>35 years) Average risk pregnancy Other: _____
 Positive serum screen: _____
 Abnormal ultrasound: _____
 History suggestive of increased risk: _____

Billing selection (select one):
 Patient pay
 Institutional
 Insurance (ICD-10 code(s) below required):
 AMA: Primigravida O09.511 1st trimester (tri) O09.512 2nd tri O09.513 3rd tri
 AMA: Multigravida O09.521 1st trimester (tri) O09.522 2nd tri O09.523 3rd tri
 Z34.90 Supervision of normal pregnancy O28.3 Abnormal ultrasonic finding
 O28.9 Abnormal finding, unspecified Other ICD-10: _____

Invitae NIPS is a laboratory-developed test that was validated under Federal CLIA laboratory guidelines by Verinata Health, Inc, a wholly owned subsidiary of Illumina, Inc. and available through contract with Invitae Incorporation.

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. For cancer, cardiology, and carrier screens 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). 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.

CANCER AND CARDIOLOGY SCREENING

11001 Invitae Genetic Health Screen (Cancer and cardiology - 147 genes)
 12001 Invitae Cancer Screen (61 genes)
 13001 Invitae Cardio Screen (77 genes)

Specimen type: Blood (6-mL purple EDTA tube) -OR- Saliva (Oragene™ kit)

Personal or family health history (optional): _____

Billing selection (select one - insurance not accepted): Patient pay Institutional

Medical professional signature (required)	Date
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