

All highlighted areas mandatory

### CLIENT INFORMATION

Account Number

Ordering Physician

NPI #

### BILLING INFORMATION

#### Bill to

Insurance/Medicare     Patient     Client

#### Patient type

Inpatient     Outpatient     Non-Hospital Patient

Prior Authorization #

Please Attach the Following:

Insurance Card Copy (Front/Back) or  Copy of Face Sheet

### TREATMENT PLAN

Please indicate considered Treatment for this patient. (Check all that apply)

Chemotherapy     Targeted Therapy     Immunotherapy

### PATIENT INFORMATION

Last Name

First Name

MI

Address

City

State

Zip

DOB

(mm/dd/yyyy)

M

F

Medical Record #

Patient #

Patient Phone #

### CLINICAL DATA

Collection Date  
(mm/dd/yyyy)

Time of Draw

am

pm

Diagnosis

ICD-10 Code(s)

Treatment Status

Pre-Treatment

Post-Treatment

Disease Stage

Stage I-II

Stage III

Stage IV

Please Attach the Following:

Pathology Report

Clinical History

### TEST MENU - TARGET SELECTOR™

#### Cancer Profiles

Non-Small Cell Lung Cancer Profile

•ALK •BRAF •EGFR Mutations\* •PD-L1 •RET •ROS1

Lung Cancer Resistance Profile

•EGFR Mutations\* •HER2 •KRAS •MET •PD-L1

Squamous Cell Lung Cancer Profile

•ALK •EGFR •FGFR1 •PD-L1 •ROS1

Gastric Profile

•HER2 •MET

Melanoma Cancer Profile

•BRAF

Colon Cancer Profile

•BRAF •KRAS

Prostate Cancer Profile

•AR

Breast Profile

•AR •ER •HER2 •PR

#### Individual markers

Please check for individual markers

ALK

EGFR

HER2

PD-L1

ROS1

AR

ER

KRAS

PR

BRAF

FGFR1

MET

RET

#### CTC Enumeration

CTC Count

\*EGFR Mutations Include: T790M, DEL19 and L858R.

### REQUIRED SIGNATURE:

\*\*By signing below, you represent on behalf of the Client that, with respect to the above-requested tests, (i) the tests are medically necessary for the care/treatment of the patient; (ii) you have obtained all necessary government, third party payer, and patient consents and approvals to request Biocept to perform the tests and to provide Biocept with all necessary information; and (iii) all information provided to Biocept in this form is accurate and correct; (iv) should the tests be denied payment by any third party payer, the Patient will be financially responsible for the costs of such tests; and (v) should this form conflict with any terms or conditions of any agreement between the parties, this form shall control.

Physician Signature\*\*

Date

(mm/dd/yyyy)

### For Biocept Use Only

# of Tubes \_\_\_\_\_ mL Rec'd. 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_

Date Received \_\_\_\_\_

QC By \_\_\_\_\_

Accessioned By

Comments

**SAMPLE REQUIREMENTS**

**Peripheral Blood:** Use four Biocept tubes, 8 mL each, a minimum of 4 mLs is needed to perform the test.

**TEST DESCRIPTION**

**Test/Technology:** Circulating Tumor Cell (CTC) analysis to include Antibody Capture and CTC detection utilizing ICC (CK, CD45, DAPI, SA) (88399, 88346 x1, 88350x2).

**TARGET SELECTOR™ ASSAYS**

Test	Technology	Result Interpretation	CPT Codes	Method
ALK	FISH	Translocation	88377	CTC
AR	Expression	Expression	88346 or 88350	CTC
BRAF	Sequencing	Mutation	81210	ctDNA
CTC	Antibody Capture	Enumeration	86152/86153 88346x1, 88350x2	CTC
EGFR (T790M, DEL19, L858R)	Sequencing	Mutation	81235	ctDNA
ER	Expression	Expression	88346 or 88350	CTC
FGFR1	FISH	Amplification	88377	CTC
HER2	FISH	Amplification	88377	CTC
KRAS	Sequencing	Mutation	81275	ctDNA
MET	FISH	Amplification	88377	CTC
PD-L1	Expression	Expression	88346 or 88350	CTC
PR	Expression	Expression	88346 or 88350	CTC
RET	FISH	Translocation	88377	CTC
ROS1	FISH	Translocation	88377	CTC