biodesix®

www.biodesix.com
Phone: 1-866-432-5930
Fax: 1-866-432-3338

ATTACH PATIENT ID LABEL HERE
(WITH PATIENT INITIALS & DATE)

Molecular Diagnostic Test Request Form

PATIENT INFORMATION (REQUIRED)

Patient Last Name:	Patient First Name:	
Street:		
City:	State:	Zip:
Date of Birth:	Gender:	Phone:
DIAGNOSTIC CODE (ICD-10):	EGFR SENSITIZING MUTATION STATUS: ❑ Positive ❑ Negative ❑ Unknown	

BILLING INFORMATION (REQUIRED—CHECK ONLY ONE BOX)

❑ **Patient insurance information is ATTACHED** ***(i.e., Patient FaceSheet)***

❑ **Patient does not have insurance - please call 1-866-432-5930 to have a financial assistance application faxed to physician**

PHYSICIAN INFORMATION (REQUIRED)

Office / Practice:		
Ordering Physician:		
Street:		
City:	State:	Zip:
Office/Practice Primary Contact:		
Phone:	Fax:	
CC Physician/Practice:	Fax :	

Test Result Delivery:

☐ Encrypted Email_____ ☐ Fax

By checking either box, you are authorizing the electronic delivery of test results by Biodesix in accordance with the Health Insurance Portability and Accountability Act and the rules reflected in the HITECH Act.

TEST MENU (REQUIRED)

Select the box next to Biodesix Lung Reflex to order the full test offering, or check any of the individual options below to order tests individually

❑ Biodesix Lung REFLEX® tests

GeneStrat *genomic test (all mutations) will reflex to* ***VeriStrat*** *proteomic test*

A LA CARTE ORDERING OPTIONS:

❑ **VeriStrat® testing only**

❑ **GeneStrat® testing only (all mutations)**

OR check individual markers *to test specific mutations:*

❑ EGFR sensitizing (del19, L858R) ❑ EGFR resistance (T790M)
❑ ALK ❑ ROS1 ❑ RET ❑ KRAS ❑ BRAF

❑ **EGFR Resistance (T790M) testing only**

To order test kits online or for more information on available tests, refer to biodesix.com

PRACTICE INFORMATION (REQUIRED)

☐ Independent Physician or Clinic
☐ Hospital or Hospital-associated Office

BLOOD DRAW INSTRUCTIONS (REQUIRED)

❑ Ambulatory Surgery Center
❑ In Office
❑ Hospital (inpatient)
❑ Hospital (outpatient)
❑ Independent Lab (enter name):
❑ Coordinate Home Phlebotomy *

** Please fax this form to 1-866-432-3338*

TREATMENT PLAN: PRIOR TO RECEIVING RESULTS, WHICH TREATMENTS WOULD YOU CONSIDER FOR THIS PATIENT (CHECK ALL THAT APPLY)

❑ Platinum Doublet	❑ Alecensa (alectinib)	❑ Platinum doublet + pembrolizumab
❑ Tagrisso® (osimertinib)	❑ Xalkori® (crizotinib)	❑ Platinum doublet + atezolizumab + bevacizumab
❑ Gilotrif® (afatinib)	❑ Zykadia® (ceritinib)	❑ Single agent chemotherapy
❑ Tarceva® (erlotinib)	❑ Alunbrig® (brigatinib	❑ Radiation Therapy
❑ Vizimpro® (dacomitinib)	❑ Keytruda® (pembrolizumab)	❑ Supportive Care / Hospice
❑ Iressa® (gefitinib)	❑ Opdivo® (nivolumab)	❑ Other: _____

PATIENT CHARACTERISTICS

Performance Status:_____ Histology: ❑ Adenocarcinoma ❑ Squamous ❑ Other:_____

AUTHORIZATION AND CERTIFICATION OF MEDICAL NECESSITY (REQUIRED)

Your signature constitutes a certification of medical necessity and intent to consider and use the results of the test(s) ordered. All of the information on this form is true and correct. You have obtained patient consent and authorize Biodesix to use and release the results and patient information for reimbursement purposes and as may be appropriate for additional clinical testing services.

_____ _____

Signature of treating physician or authorized representative Date

Medicare Signature Requirements for providers define a valid signature as "handwritten or electronic." Please provide a wet ink or electronic signature on this form. If you are unable to do so, please contact Biodesix Customer Care at 1-866-432-5930.

