Biocept
Completing the Answer™

Target Selector Test Requisition

All highlighted areas required.

CLIENT INFORMATION

Account Number

Referring Physician

NPI #

BILLING INFORMATION

Bill to

☐ Insurance/Medicare ☐ Patient ☐ Non-Hospital Patient
☐ Inpatient ☐ Outpatient ☐ Client

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* •RET •ROS1

☐ **Lung Cancer Resistance Profile**
•EGFR Mutations* •HER2 •KRAS •MET

☐ **Squamous Cell Lung Cancer Profile**
•FGFR1

☐ **Gastric Profile**
•HER2 •MET

☐ **Melanoma Cancer Profile**
•BRAF

☐ **Colon Cancer Profile**
•BRAF •KRAS

☐ **Prostate Cancer Profile**
•AR

☐ **Breast Profile**
•AR •ER •HER2

Individual markers

Please check for individual markers

☐ ALK ☐ EGFR ☐ HER2 ☐ PD-L1
☐ AR ☐ ER ☐ KRAS ☐ RET
☐ BRAF ☐ FGFR1 ☐ MET ☐ ROS1

CTC Enumeration

☐ **CTC Count** ☐ Cancer Type*** _____

***If cancer type is not indicated, Biocept will use a standard carcinoma antibody cocktail to perform analysis.

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

For Biocept Use Only

of Tubes _____ mL Rec'd. 1 ____ 2 ____ 3 ____ 4 ____

Accessioned By _____

Date Received _____ QC By _____

Comments _____

REQUIRED SIGNATURE:

**Your signature constitutes a Certificate of Medical Necessity and a certification that you have obtained the patient's consent for Biocept's release of the test results to the patient's third party payer when necessary as part of the reimbursement process.

Physician Signature**

_____

Date (mm/dd/yyyy)

Biocept, Inc.
5810 Nancy Ridge Drive, San Diego, CA 92121
Customer Service 888-332-7729 • **FAX** 877-300-1761

www.biocept.com

LIT 1682.04

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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
RET	FISH	Translocation	88377	CTC
ROS1	FISH	Translocation	88377	CTC

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