

All highlighted areas are mandatory

CLIENT INFORMATION
Account Number
Ordering Physician
NPI #

PATIENT INFORMATION		
Last Name	First Name	MI
Address		
City	State	Zip
DOB	(mm/dd/yyyy)	<input type="checkbox"/> M <input type="checkbox"/> F
Medical Record #		
Patient Phone #		

BILLING INFORMATION	
Bill to <input type="checkbox"/> Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Patient <input type="checkbox"/> Client	Patient type <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Non-Hospital Patient
Prior Authorization #	
Please Attach the Following:	
<input type="checkbox"/> Insurance Card Copy (Front/Back) or <input type="checkbox"/> Copy of Face Sheet	

CLINICAL DATA		
Collection Date (mm/dd/yyyy)	Time of Draw	<input type="checkbox"/> am <input type="checkbox"/> pm
Diagnosis		
Clinical Status	<input type="checkbox"/> At Diagnosis	<input type="checkbox"/> Progression <input type="checkbox"/> Monitoring*
ICD-10 Code(s)		
Treatment Status	<input type="checkbox"/> Pre-Treatment	<input type="checkbox"/> On Treatment <input type="checkbox"/> Post-Treatment
Disease Stage	<input type="checkbox"/> Stage I-II	<input type="checkbox"/> Stage III <input type="checkbox"/> Stage IV
Please Attach Both of the Following:		
Pathology Report and Clinical History		

MEDICAL NECESSITY
Testing Ordered is Medically Necessary: (Check all that apply)
<input type="checkbox"/> To guide treatment considerations <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Targeted Therapy <input type="checkbox"/> Immunotherapy <input type="checkbox"/> Other _____
<input type="checkbox"/> To assess prognosis <input type="checkbox"/> To assess treatment response
<input type="checkbox"/> Tissue biopsy was not feasible <input type="checkbox"/> Other: _____

*Monitoring with Biocept testing is recommended for:
 » Active Cancer (continuous cancer 5, 10, 15, etc. years); or,
 » Cancer Free – Remission – within last 5 years of test order date.

TEST MENU - TARGET SELECTOR™	
Cancer Profiles Minimum of 4mL CSF required <input type="checkbox"/> Breast Cancer Profile • ER • HER2 • NTRK1 • NTRK3 • PD-L1 Minimum of 4-6mL CSF required <input type="checkbox"/> Lung Cancer Profile • ALK • BRAF • EGFR Mutations • MET • NTRK1 • NTRK3 • PD-L1 • RET • ROS1 <input type="checkbox"/> Non-Small Cell Lung Cancer Profile with NGS • NGS Lung Panel • PD-L1 • NTRK1 • NTRK3 NGS (next generation sequencing) <input type="checkbox"/> Target Selector™ Next-Generation Sequencing (NGS) Lung Panel • ALK • BRAF • EGFR • ERBB2 • KRAS • MAP2K1 • MET • NRAS • PIK3CA • RET • ROS1 • TP53	Individual Markers (Please check all that apply) Minimum of 2mL CSF required for ≥1 ctDNA marker ctDNA (Circulating Tumor DNA) • Molecular <input type="checkbox"/> EGFR (Mutations: L858R, DEL19, T790M) <input type="checkbox"/> KRAS <input type="checkbox"/> BRAF Minimum of 2mL CSF required for 1 expression and ≥2 FISH CTC markers CTC (Circulating Tumor Cells)—Validated tumor types: NSCLC and Breast • Expression <input type="checkbox"/> AR <input type="checkbox"/> AR-V7 <input type="checkbox"/> ER <input type="checkbox"/> pan-TRK* <input type="checkbox"/> PD-L1 <input type="checkbox"/> PR **Reflex to NTRK1 and NTRK3 by FISH if pan-TRK expression is positive. • FISH <input type="checkbox"/> ALK <input type="checkbox"/> EGFR <input type="checkbox"/> FGFR1 <input type="checkbox"/> HER2 <input type="checkbox"/> MET <input type="checkbox"/> MYC <input type="checkbox"/> NTRK1 <input type="checkbox"/> NTRK3 <input type="checkbox"/> PTEN <input type="checkbox"/> RET <input type="checkbox"/> ROS1 Other Biocept Tests _____

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 payor, 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 payor, 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. Extra patient specimen not needed for clinical testing may be used for internal testing validation in a de-identified manner.
Physician Signature*** _____ Date _____ (mm/dd/yyyy)

For Biocept Use Only	# of Tubes _____ Tube Type _____
	mL Rec'd. 1 _____ 2 _____ 3 _____ 4 _____
	Expiration Date _____ Lot # _____
	Received (initials, date) _____
	Comments _____

SAMPLE REQUIREMENTS

Cerebral Spinal Fluid (CSF): Use one Biocept tube to collect a minimum of 2mL of CSF. For every 2mL of CSF, one expression and two FISH markers can be run. Please include appropriate volume of CSF based on number of desired biomarkers.

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, 88350 x2).

TARGET SELECTOR™ ASSAYS

Test	Technology	Result Interpretation	CPT Codes*	Method
ALK	FISH	Fusion/Translocation	88377	CTC
AR	Expression	Expression	88346 or 88350	CTC
AR-V7	Expression	Expression	88346 or 88350	CTC
BRAF	Sequencing	Mutation	81210	ctDNA
CTC	Antibody Capture	Enumeration	86152/86153, 88346 x1, 88350 x2	CTC
EGFR	FISH	Amplification	88377	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
MYC	FISH	Amplification	88377	CTC
NGS Lung Panel	NGS	Amplification, Mutation, and Translocation	81445	ctDNA
NTRK1	FISH	Fusion	88377	CTC
NTRK3	FISH	Fusion	88377	CTC
pan-TRK	Expression	Expression	88346 or 88350	CTC
PD-L1	Expression	Expression	88346 or 88350	CTC
PR	Expression	Expression	88346 or 88350	CTC
PTEN	FISH	Gene Loss	88377	CTC
RET	FISH	Fusion/Translocation	88377	CTC
ROS1	FISH	Fusion/Translocation	88377	CTC

*These CPT Codes are representative of general CPT Code that may apply to the testing services requested. Selection of the appropriate CPT Code for any particular test should be performed by a qualified, certified coder based on the patient's individual medical file and treating physician's judgment.