IDHNow for AML
Sponsored Testing Program Requisition

Phone 866.776.5907
Fax 239.690.4237

Program Description:
Eligible patients may receive one (1) IDHNow for AML (IDH1/IDH2 Mutation Analysis by PCR) test regardless of test results or treatment decision. Patients must meet all of the following criteria to be eligible:

- Patient has newly diagnosed AML, not previously treated
- Patient does not have a known IDH1 mutation from a previous test
- Patient lives and receives treatment in the United States or a US territory
- Patient has not previously been tested under this Program

No patient, health care program, or beneficiary shall be billed for this test. This test shall not be included in a bundled payment to any healthcare facility including, but not limited to, a hospital. The ordering physician shall not be compensated any fees in connection with this testing, such as for specimen collection, handling, or data reporting. Program is not valid where prohibited by law. NeoGenomics and Servier reserve the right to rescind, revoke, or amend the program for any reason without notice.

Client Information

Required Information

Account #: _____ **Account Name:** _____

Street Address: _____

_____

City, ST, ZIP: _____

Phone:_____ **Fax:**_____

Additional Reporting Fax: _____

Requisition Completed by:_____ Date: _____

Ordering Physician (please print: Last, First): _____

NPI #:_____

Treating Physician (please print: Last, First): _____

NPI #:_____

The undersigned certifies that he/she is (1) licensed to order the test(s) listed below and he/she agrees to the terms in Program Description; (2) that such test(s) are medically necessary for the care/treatment of this patient; and (3) patient meets eligibility requirements and has provided consent to perform the services described.

Authorized Signature: _____ **Date:** _____

Specimen Information

☐ **Mobile Phlebotomy Request**

NeoGenomics will reach out to patient to schedule appointment

Patient Phone: _____

Specimen ID:_____ **Block ID:** _____

Fixative/Preservative: _____

Collection Date: mm _____ / dd ____/ yyyy_____ **Collection Time:**____ ☐ AM ☐ PM

Retrieved Date: mm_____ / dd ____/ yyyy_____

Hospital Discharge Date: mm _____ / dd _____ / yyyy _____

Body Site: _____

☐ Primary

☐ Metastasis — If Metastasis, list Primary: _____

☐ Bone Marrow **[must provide CBC Report]:**
Green Top(s) _____ Purple Top(s) _____Core Biopsy_____Clot _____

☐ Peripheral Blood: Green Top(s) _____ Purple Top(s) _____ Other _____

Clinical Information

Required: Please attach patient's pathology report (required), clinical history, and other applicable report(s).

ICD 10 (Diagnosis) Code/Narrative (Required): _____

Reason for Referral: _____

☐ New Diagnosis ☐ Relapse ☐ In Remission ☐ Monitoring

Staging: ☐ 0 ☐ I ☐ II ☐ III ☐ IV

Notes: _____

_____

_____

Patient Information

Last Name: _____ ☐ **Male** ☐ **Female**

First Name: _____ **M.I.** _____

Other Pt ID/Acct #: _____

Date of Birth: mm_____ / dd _____ / yyyy _____

Medical Record #: _____

By completing this section, Client represents it has obtained informed consent from patient to perform the services described herein.

Select Testing

☐ **IDH1/IDH2 Mutation Analysis by PCR, Sponsored Testing Program**

Program Overview

Please see our website for details of the IDHNow for AML Sponsored Testing Program:
https://neogenomics.com/diagnostic-services/sponsored-testing-programs/idhnow-aml-sponsored-testing-program

Specimen Requirements

Peripheral blood: 5 mL in EDTA tube.

Bone marrow: 2 mL in EDTA tube.