AVISE® Test Requisition

Provider Relations: 888.452.1522

STEP 1 — Patient & Provider Information *(Required)*

Patient Details

Full Name: ______________________

Address: ______________________

City: ____________ State: ________ Zip: ________

Phone: ______________________ ☐ Male ☐ Female

DOB: _____ /_____ /_____ MRN: ______________

Attach a copy of front and back of insurance cards

BILLING INFORMATION: ☐ Insurance ☐ Patient ☐ Lab

MEDICARE only Hospital: ☐ Non-hospital patient ☐ In-patient ☐ Out-patient

Provider Details

Provider Name: ______________________

NPI #: ______________________

Practice Name: ______________________

Address: ______________________

City: ____________ State: ________ Zip: ________

Phone: ____________ Fax: ____________

Lab Name: ____________ Zip: ________

☐ Fax results to Lab. Fax # ______________

STEP 2 — Diagnosis: ICD-10 Codes *(Required)*

Provide ICD-10 Diagnosis Codes (highest level of specificity) that are medically appropriate for the patient's condition and consistent with the patient's medical record.

ICD-10 CODES *(Required)*: __________/ __________/__________/__________/__________

The following codes are provided as **examples** only:

For AVISE MTX: Per Medicare policy, please identify (1) M-Code and (1) Z-Code

- *Other specified disorders involving the immune mechanism, not elsewhere classified:* ***D89.89***
- Personal history of other drug therapy: ***Z92.29***
- RA with rheumatoid factor of multiple sites without organ or systems involvement: ***M05.79***

*Note: Medicare recently added multiple site ICD-10 codes in support of methotrexate monitoring for RA patients and no longer accepts unspecified codes.

STEP 3 — Specimen Information & Test Order

Date Specimen(s) Collected: *(Required)* _____/_____/_____ **Time of Collection:** __________

☐ **AVISE CTD** — 10 mL whole blood EDTA (lavender tube); 5 mL serum SST (tiger top tube)

Includes AVISE Lupus Profile

- ☐ Add **AVISE SLE Prognostic** regardless of AVISE Index result
- ☐ Add **AVISE SLE Prognostic** if AVISE Index is POSITIVE
- ☐ Add **Anti-Histone**
- ☐ Add **Anti-CarP**

☐ **AVISE SLE Monitor** — 10 mL whole blood EDTA (lavender tube); 5 mL serum SST (tiger top tube)

- ☐ Include **AVISE HCQ - Current dose:** __________ **mg/day**
  Specimen should be collected at least 4 hours after last dose
- ☐ Include **AVISE MTX - Current dose:** __________ **mg/week**
- ☐ Include **Hematology/Chemistry** [1][CBC + Diff [2], Creatinine, CRP]

[1]only available with SLE Monitor [2]w/reflex to manual if indicated

☐ **AVISE SLE Prognostic** — 5 mL serum SST (tiger top tube)

☐ **AVISE Anti-CarP** — 5 mL serum SST (tiger top tube)

☐ **AVISE APS** — 5 mL serum SST (tiger top tube)

☐ **AVISE HCQ** — 5 mL whole blood EDTA (lavender tube)
Current dose: __________ **mg/day**
Specimen should be collected at least 4 hours after last dose

☐ **AVISE Vasculitis-AAV** — 5 mL serum SST (tiger top tube)

☐ **AVISE MTX** — 5 mL whole blood EDTA (lavender tube)
Current dose: __________ **mg/week**
☐ Injection Or ☐ Number of pills/week ________

STEP 4 — Medically Necessary

I certify that the ordered test(s) is(are) reasonable and medically necessary for the diagnosis, care, and treatment of this patient's condition.

Physician signature: ______________________ Date: ______________

Print Name: ______________________

For additional AVISE testing options please see page 2.

AVISE Test Components and Descriptions

(Additional analyte requests may be indicated here)

☐ AVISE CTD

AVISE Lupus Profile

☐EC4d
☐BC4d
☐Anti-dsDNA
(reflex to Crithidia if positive)
☐ANA (HEp-2 IFA)
☐ANA (ELISA)
☐Anti-Sm
☐Anti-CCP
☐Jo-1
☐Scl-70
☐CENP
☐SS-B/La

☐ **ENA**
- ☐ U1RNP
- ☐ RNP70
- ☐ Ro52
- ☐ Ro60
- ☐ RNA Pol III
- ☐ Histone

☐ **APS**
- ☐ aCL
  - ☐ IgG
  - ☐ IgM
- ☐ β2 GP1
  - ☐ IgG
  - ☐ IgM

☐ **RA**
- ☐ RF IgM
- ☐ RF IgA

☐ **Thyroid**
- ☐ TPO
- ☐ TG

☐ AVISE Lupus Profile

☐EC4d
☐BC4d
☐Anti-dsDNA
(reflex to Crithidia if positive)
☐ANA (HEp-2 IFA)
☐ANA (ELISA)
☐Anti-Sm
☐Anti-CCP
☐Jo-1
☐Scl-70
☐CENP
☐SS-B/La

☐ Anti-CarP

☐ AVISE SLE Prognostic

☐ C1q
☐ Ribosomal P
☐ PS/PT
- ☐ IgG
- ☐ IgM

☐ aCL
- ☐ IgG
- ☐ IgM
- ☐ IgA

☐ β2 GP1
- ☐ IgG
- ☐ IgM
- ☐ IgA

☐ AVISE SLE Monitor

☐ EC4d
☐ C1q
☐ dsDNA CIA
☐ PC4d
☐ C3
☐ C4
☐ CBC+Diff[1]
☐ Creatinine
☐ CRP

(CBC+Diff, Creatinine, CRP: only available with SLE Monitor)

[1] w/reflex to manual if indicated

☐ AVISE APS

☐ aCL
- ☐ IgG
- ☐ IgM
- ☐ IgA

☐ β2 GP1
- ☐ IgG
- ☐ IgM
- ☐ IgA

☐ PS/PT
- ☐ IgG
- ☐ IgM

☐ AVISE Vasculitis-AAV

☐ Anti-PR3
☐ Anti-MPO
☐ Anti-GBM
☐ ANCA (IFA)

AVISE Specimen Requirements

Order Type	Tube Requirements
Up to 2 AVISE tests	**one**- 10 mL whole blood EDTA (lavender tube) **one**- 5 mL serum SST (tiger top tube)
3 or more AVISE tests	**two**- 10 mL whole blood EDTA (lavender tubes) **one**- 5 mL serum SST (tiger top tube)

AVISE Specimen Submission

PREPARE SPECIMEN COLLECTION KIT FOR SHIPPING:

Ship specimens Monday through Friday on same day blood is drawn, priority overnight delivery, using pre-printed shipping label.

1. Insert frozen cold pack in one of the cooler wells.
2. Enclose specimen(s) in Bio-Hazard specimen bag and place bag inside the alternate well, away from the cold pack. **Specimens from multiple patients may be included in the same box.**
3. Replace foam cooler lid and place the completed test requisition(s) and insurance card copies on top of cooler before closing outer transportation kit box.
4. **Place kit inside plastic carrier bag and affix shipping label to bag.**
5. **Contact carrier indicated on the prepaid shipping label for pick-up or call Exagen Provider Relations at 888.452.1522 for assistance.**

QUESTIONS?

Call **888.452.1522** or visit **www.AviseTest.com** or email shipping@exagen.com to place a kit order.

AVISE tests are used for clinical purposes, though results provided are not intended to be used as the sole means for clinical diagnosis or patient management decisions. AVISE tests should not be regarded as investigational or for research. AVISE tests were developed and performance characteristics determined by Exagen Inc. While some components of AVISE tests are FDA approved devices, the integrative test methods have not been cleared or approved by the FDA. Exagen is regulated under CLIA as qualified to perform high complexity testing. Exagen, AVISE, and the Exagen and AVISE logos are registered trademarks of Exagen Inc.

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Advance Patient Notification (APN)
(Do not use for Medicare/Medicaid/Tricare Patients)
Please submit this form with your AVISE test requisition

Your physician ordered an innovative AVISE blood test for you from Exagen Inc.
By signing below, I acknowledge and understand that I will be responsible for any out of network and/or out of pocket costs.

I authorize Exagen Inc. to pursue all necessary appeals for payment on my behalf with my health insurance company in relation to services provided. If my health insurance company sends payment to me, I agree to pay Exagen Inc. in full the amount of such payment.

Patient Name (Print) ________________________________ **Phone** ____________________

Patient (Parent/Guardian) Signature ________________________________ **Date** __________

Expiration date of authorization if other than 24 months: Date __________

LAB USE ONLY	**Date of Service**____________

Notificación al paciente (APN)
(No utilice este formulario para pacientes de Medicare/Medicaid/Tricare)
Por favor, presente este formulario con su solicitud de la prueba AVISE

Su médico ordenó el innovador análisis de sangre AVISE, de la empresa Exagen Inc.
Al firmar este formulario, reconozco y comprendo que seré responsable de cualquier costo fuera de la red de mi seguro de salud asi como cualquier pago adicional.

Autorizo a Exagen Inc. para que persiga todas las apelaciones necesarias para el pago de los servicios brindados, en mi nombre, con mi compañía de seguro de salud. Si mi compañía de seguro de salud me envía el pago, yo se lo enviaré a Exagen Inc. por completo.

Nombre del paciente (en letra de molde) __________________ **Teléfono** ________________

Firma del paciente (padre/tutor) ________________________________ **Fecha** _________

Fecha de vencimiento de la autorización si no es de 24 meses: Fecha __________

USO DEL LABORATORIO SOLAMENTE	**Fecha de Servicio**____________

Financial Assistance Program (FAP)
We also offer flexible payment plans

Number of people in your household	$0 Patient Out-of-pocket cost if family taxable annual income is at or below:
1	$38,280
2	$51,720
3	$65,160
4	$78,600
5	$92,040

Exagen offers an FAP based on your family size and annual taxable income. Please refer to the chart on the left for eligibility guidelines.

Please contact our AVISE Patient Advocate Team to assist with confirming your eligibility at 1.888.452.1522, Option 2.

Approximate Family Annual Income		Number of People in Your Household	

Have questions? Please call us today at 888.452.1522, Option 2.

We are standing by to help.

Programa de Asistencia Financiera (FAP)
También ofrecemos planes de pago flexibles

Número de personas en su hogar	$0 Costo al paciente si el ingreso anual familiar es o menos de:
1	$38,280
2	$51,720
3	$65,160
4	$78,600
5	$92,040

Exagen ofrece un Programa de Asistencia Financiera basada en el número de miembros de su familia y el ingreso familiar anual. Por favor, consulte el cuadro para determinar si es elegible.

Para confirmar su elegibilidad, favor de comuníquese con nuestro Equipo de Apoyo de AVISE al 1.888.452.1522, y elija la opción 2.

Ingreso familiar anual aproximado		Número de personas en su hogar	

¿Tiene preguntas? Llámenos hoy al 888.452.1522 y elija la opción 2.

Estamos listos para ayudarle.