

AVISE® Test Requisition

Provider Relations: 888.452.1522



STEP 1

Patient & Provider Information (Required)

Patient Details

Attach a copy of front and back of insurance cards

Full Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Male Female

DOB: ____/____/____ MRN: _____

BILLING INFORMATION Bill: Insurance Patient Lab

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

Test Menu

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

AVISE CTD 10 mL Whole Blood EDTA (lavender tube)
5 mL Serum SST (tiger top tube)

- Add **AVISE SLE Prognostic** regardless of AVISE Index result
- Add **AVISE SLE Prognostic** if AVISE Index is POSITIVE
- Add **anti-Histone**

AVISE SLE Prognostic 5 mL Serum SST (tiger top tube)

AVISE APS 5 mL Serum SST (tiger top tube)

AVISE SLE Monitor 10 mL Whole Blood EDTA (lavender tube)
5 mL Serum (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

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 MTX 5 mL Whole Blood EDTA (lavender tube)
Current dose: _____ mg/week
 Injection Or Number of pills/week _____

AVISE Test Components and Descriptions

(Additional analyte requests may be indicated here)

AVISE CTD

AVISE Lupus (EC4d, BC4d, Anti-dsDNA (reflex to Crithidia if positive) ANA, Anti-Sm, Anti-CCP, Jo-1, Scl-70, CENP, and 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 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

AVISE APS

- aCL
- IgG
- IgM
- IgA
- β2 GP1
- IgG
- IgM
- IgA
- PS/PT
- IgG
- IgM

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.**

RUNNING LOW ON SPECIMEN COLLECTION KITS?

Select a quantity and we will ship them to you:

- | | | | |
|--|-------------------------------|-------------------------------|-------------------------------|
| Specimen Collection Kits | <input type="checkbox"/> 4 | <input type="checkbox"/> 8 | <input type="checkbox"/> 10 |
| AVISE CTD Patient Brochure (25 per pack) | <input type="checkbox"/> 1 pk | <input type="checkbox"/> 2 pk | <input type="checkbox"/> 3 pk |
| AVISE SLE Monitor Patient Brochure (25 per pack) | <input type="checkbox"/> 1 pk | <input type="checkbox"/> 2 pk | <input type="checkbox"/> 3 pk |

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.

© Exagen Inc. 2020. All rights reserved.

Exagen[®]
Patient Focused. Discovery Driven.

Exagen Inc. Laboratory Directors: Richard Safrin, MD, and Thierry Dervieux, PhD, DABCC. CLIA#05D1075048 CAP#7201051 PFI#8369 LM1028 (3/20)

Exagen Inc. | 1261 Liberty Way, Suite C | Vista, California 92081
Tel: 888.452.1522 | Fax: 888.452.8344 | www.AviseTest.com

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 así 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.