PATHOLOGY PREORDER FORM

Please send specimen with this form, and enclose a completed HERmark® Breast Cancer Assay Test Request Form.

Monogram Biosciences, Inc., 345 Oyster Point Blvd, South San Francisco, CA 94080
Samuel H. Pepkowitz, MD, Medical Director Telephone: (800) 777-0177 Fax: (650) 615-0177
www.hermarkassay.com

1. **FAX TO PATHOLOGY – FAX NUMBER: (   )____________________**
2. **FAX TO MONOGRAM BIOSCIENCES - FAX NUMBER: (650) 615-0177**

Instructions for the Oncologist: On the HERmark Pathology Preorder Form, please complete sections 1, 2, and 3. Please submit this form to your Pathology Laboratory and fax to Monogram Biosciences at (650) 615-0177.

Instructions for the Pathology Laboratory: If you do not have the HERmark Breast Cancer Assay Test Request Form and shipping kit, please call Monogram Biosciences at **1-800-777-0177**. On the HERmark Test Request Form, please write the patient name in section 1. Please attach this form to the Test Request Form and submit with the specimen to Monogram Biosciences.

1) PATIENT INFORMATION

Patient Name:____________________ DOB:________
Last First MI

Patient ID or Medical Record #:________________

Address:____________________
Street City State ZIP

Reference/Order/Case #:________________

Telephone:________________ SEX: ☐ M ☐ F

2) BILLING INFORMATION

Check one box for billing type and fill out all accompanying information. Attach a copy of the front and back of insurance card(s).

Primary Diagnosis:
____

Diagnosis/Signs/Symptoms in ICD-CM format in effect at Date of Service (Highest Specificity Required):
____

☐ **Private Insurance**

Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent ☐ Legal Partner

Primary Health Plan Name:________________

Primary Insured ID #:________________

Primary Insurance Telephone:________________

Secondary Health Plan Name:________________

Secondary Insured ID #:________________

☐ **Medicare** > Patient Medicare #:____________

☐ **Medicaid** > Patient Medicaid #:____________

☐ **Client**

☐ **Patient Self-Pay** (Check, money order, or credit card)

Name on Credit Card:____________

Credit Card #:____________

Exp. Date:________ Security Code:________

3) ORDERING INFORMATION

Oncologist/Physician Name:________________

Facility Name:________________

Address:________________
Street City State ZIP

Telephone:____________ Fax:____________

E-mail Address:________________

ID/License #:____________ NPI #:____________

The HERmark Breast Cancer Assay provides an accurate and quantitative measurement of HER2 protein expression. In my judgment, the HERmark Breast Cancer Assay is medically necessary for this patient.

X____________________ Date:________
Signature of Ordering Physician

INTERNAL USE ONLY:

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