CASTLE BIOSCIENCES
235 William Pitt Way B1
Pittsburgh, PA 15238
Customer Service: 866-788-9007

Fax completed form to: 866-329-2224
Alternate fax: 602-222-5200

DecisionDx ▸SCC

Requisition Form

I. Ordering Entity Information

Name of Ordering Physician, PA, NP*

Specialty NPI

Address*

City / State / Zip*

( ) ( )
Telephone* Fax*

Institution / Practice Name*

II. Patient Information

Last Name* First Name* MI

DOB* Gender SSN / MR#

Address*

City / State / Zip*

( )
Telephone*

Email

III. Billing Information

Submitting Diagnosis ICD-10 Code*

Method of Payment:
- ☐ Private Insurance ☐ Patient Self-Pay
- ☐ Medicare ****Section IV required*** ☐ Medicaid
- ☐ Client Bill *(contracted entities only)*

Primary Insurance Co. Name Policy#

( )
Insurance Co. Phone#

Secondary Insurance? ☐ Yes ☐ No
(If yes, attach copy of front/back of secondary insurance card)

IV. Medicare Only **REQUIRED for patients with traditional Medicare as primary insurance*

At time of tissue collection, was this patient: ☐ Non-hospital ☐ Hospital Outpatient ☐ Hospital Inpatient If hospital inpatient, date of discharge: ____________

If specimen is stored for more than 30 days from the date of collection, please provide the date specimen is pulled from archive: ____________

V. Clinical Information **REQUIRED (This test is validated for patients with one or more high-risk features. Please check all that apply from the table below)*

HISTORY AND PHYSICAL EXAM
- ☐ Tumor size ≥2cm anywhere on the body
- ☐ Tumor location on the head, neck, hands, genitals, feet or pretibial surface *(areas H or M)*
- ☐ Immunosuppression
- ☐ Rapidly growing tumor
- ☐ Tumor with poorly defined borders
- ☐ Tumor at site of prior radiation therapy or chronic inflammation
- ☐ Neurologic symptoms in region of tumor

SURGICAL AND PATHOLOGY FINDINGS
- ☐ Perineural involvement *(Large (≥0.1 mm) or named nerve involvement; Small (<0.1 mm) in caliber)*
- ☐ Poorly differentiated tumor histology
- ☐ Depth *(Invasive beyond subcutaneous fat **or** Invasion beyond 2mm **or** Clark Level IV)*
- ☐ Aggressive histologic subtype[A]
- ☐ Lymphovascular invasion
- ☐ Desmoplastic SCC

DecisionDx-SCC has not been evaluated for testing in tissue from locally recurrent tumors

[A]Acantholytic (adenoid), adenosquamous (showing mucin production), carcinosarcomatous (metaplastic) or desmoplastic subtypes (others will be considered on a case-by-case basis).

VI. Required Signature

X
SIGNATURE OF TREATING CLINICIAN*

Printed Name

Date

This signature confirms this test to be medically necessary for this patient. This clinician provides consultation and/or treatment for Squamous Cell Carcinoma and will use the results in the management of the patient.

VII. Additional Order Information

Name of Treating Clinician *(if different than section I)*

( ) ( )
Phone # Fax#

Mailing Address (☐ same as requestor)

City / State / Zip

Institution/Practice Name

Email address for report notification

Additional Clinician *(optional)*

( ) ( )
Phone # Fax#

Mailing Address (☐ same as requestor)

City / State / Zip

Institution/Practice Name

Email address for report notification

VIII. Laboratory Information

Please fax this requisition along with a copy of the pathology report from the primary biopsy and Mohs report *(if applicable)*

Facility where tissue is maintained: ____________ Date of Collection: ____________

Phone: ____________ Fax: ____________

FOR INTERNAL USE ONLY

Received: ____________ Processed by: ____________ Materials received: ____________

PR/Initials: ____________ DTL: ____________ Note: ____________

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DecisionDx SCC

Requisition Form

Requisition Form Completion Instructions

1. **Section I**: Complete with information of the ordering Entity.

2. **Section II**: Complete with patient information.

3. **Section III**: Provide the ICD-10 code and patient's diagnosis. Select Method of Payment. Please complete with billing information including a copy of the front and back of the insurance card (if applicable). If the person completing this requisition is not in possession of the information necessary for completion of the billing information section, please provide the name/department and contact information of the appropriate party from whom this information can be obtained:
   Name: ______________________ Department: ______________________
   Phone: ______________________ Fax: ______________________

   *If a copy of the front and back of the insurance card is provided, no further information is needed in this section of the requisition. A billing face sheet is also sufficient, in lieu of copy of card.

4. **Section IV**: Applicable only for patients with Traditional Medicare as their primary insurance.

5. **Section V**: This test is validated for patients with squamous cell carcinoma tumors which have at least one high risk feature. This/these feature(s) can be either clinical in nature, or pathology derived, or both. Please select all that apply from the list provided in section V titled "Clinical Information". Note: DecisionDx-SCC has not been evaluated for testing in tissue from locally recurrent tumors.

6. **Section VI:** The ordering clinician must sign this section. **For purposes of ordering this test, the "ordering clinician" section can be signed only by a physician, advanced practice registered nurse (APRN) or representative Physician Assistant (PA)**

7. **Section VII:** Complete with information for the treating clinician and/or additional clinicians. If the mailing address is the same as for the ordering clinician, check the box "same as requestor". Be sure to select the preferred method by which results should be communicated and provide an email address if you wish to receive electronic notification that the report is available.

8. **Section VIII:** Complete this section with the name of the facility where the tissue from which slides for testing will be requested. Provide the name and phone # of an individual to whom a tissue request should be made.

FAX THE FOLLOWING DOCUMENTS TOLL FREE AT 1-866-329-2224
(Alternate fax: 602-222-5200)

*Order confirmation will be sent to the ordering clinician via fax within 24 hours of receipt

- ☐ Completed requisition
- ☐ Pathology and Mohs reports *(if applicable)*
- ☐ Signed letter of medical necessity