Client Services
Phone: (833) 243-4552
Fax: (629) 235-4545
Email: clientservices@vericidx.com

TEST REQUISITION FORM

To avoid delays, please fill out the entire form

Verici Dx use only:

Accession #:

Received By:

Received Date:

Items Received:

ACCOUNT INFORMATION

TRANSPLANT CENTER | VERICI DX ACCOUNT #

STREET ADDRESS

CITY | STATE | ZIP

PHONE NUMBER | FAX NUMBER

OFFICE CONTACT

EMAIL ADDRESS

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, INITIAL)

PATIENT ID # / MEDICAL RECORD # | ☐ FEMALE ☐ MALE | BIRTH DATE (MM/DD/YYYY)

STREET ADDRESS

CITY | STATE | ZIP

DAYTIME PHONE NUMBER | EMAIL ADDRESS

RACE AND ETHNICITY

☐ WHITE ☐ BLACK OR AFRICAN AMERICAN ☐ HISPANIC OR LATINO
☐ ASIAN ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ NATIVE HAWAIIAN OR PACIFIC ISLANDER
☐ MULTIRACIAL

PATIENT CLINICAL INFORMATION

Date of Transplant (MM/DD/YYYY):

Type of Transplant: ☐ Cadaveric Donor ☐ Living Donor

DIAGNOSIS INFORMATION

ICD-11 CODES ARE REQUIRED

ICD-11 Code/s: _____

BILLING INFORMATION (Choose one option and provide the necessary information)

☐ Insurance	A legible copy of both sides of insurance cards. Indicate which is primary. Testing may be delayed if not received with the sample.
☐ Self-Pay	Patient will be contacted once sample is received to complete this process and set up payment or payment plan.
☐ Client	Client Name: Client Contact:
☐ Other Third Party	Pay Source: Contact Information:

INSURANCE INFORMATION (If applicable)

PRIMARY INSURANCE NAME | PRIMARY INSURANCE ID

SECONDARY INSURANCE NAME | SECONDARY INSURANCE ID

SUBSCRIBER NAME | SUBSCRIBER DATE OF BIRTH (MM/DD/YYYY)

PATIENT RELATIONSHIP TO SUBSCRIBER

SPECIMEN COLLECTION DATE (MM/DD/YYYY)_____ COLLECTION TIME_____ ☐ AM ☐ PM

TEST DESCRIPTION

Tutivia™ is an in vitro prognostic assay that analyzes the gene expression of multiple RNA biomarkers from peripheral blood collected within 6 months following kidney transplant surgery. A clinically validated cutoff and risk score classifies kidney transplant patients as either low or high risk for clinical and or sub-clinical acute rejection as determined by histopathology in a kidney biopsy. The Verici Dx Tutivia™ test is intended for professional use only, and results should be interpreted in the full context of clinical findings.

AUTHORIZED SIGNATURE

Physician Name: _____ **NPI:** _____ **Email Address:** _____

I am a licensed medical professional. I acknowledge that the test requested herein is medically necessary and the patient is eligible for the test. I attest that the documentation of medical necessity for tests ordered is documented in the patient's medical record, which will be made available upon request of performing laboratory and/or third-party payer.

Physician's Signature: _____ **Date:**_____

IMPORTANT SAMPLE PROCESSING INFORMATION

Sample Collection: 2.5 mL of peripheral blood in PAXgene® Blood RNA IVD tube containing preservative (provided in the tube)

Recommended Handling:

- Upon collection of peripheral blood, the tube must be inverted, **not shaken**, 8-10 times to mix in the preservative.
- After mixing, the tube must be upright at ambient temperature (18-25°C) for a minimum of 2 hours (maximum 48 hours).
- Tube should be moved to a -20C to -80C freezer overnight
- Follow packaging instructions provided with shipper
- The sample is to be shipped on dry ice for overnight delivery to Verici Dx laboratory.

Shipping Address: Ship specimen and Test Requisition form to: Verici Dx, 393 Nichol Mill Lane, Suite 200, Franklin, TN 37067, USA