

CLIENT INFORMATION	
ORDERING PHYSICIAN	NPI #
TREATING PHYSICIAN	NPI #
PHYSICIAN/AUTHORIZED SIGNATURE	

PATIENT INFORMATION	
Name (LAST, FIRST, MI):	
Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Address:	
City, State, Zip:	
Phone Number:	
Med. Rec. # / Patient #:	

BILLING INFORMATION (attach face sheet and copy of insurance card – both sides)	
Bill: <input type="checkbox"/> My Account <input type="checkbox"/> Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Patient <input type="checkbox"/> Workers Comp	
Patient Hospital Status: <input type="checkbox"/> In-Patient <input type="checkbox"/> Out-Patient <input type="checkbox"/> Non-Patient	
Insurance Information: <input type="checkbox"/> See attached Authorization # _____	
PRIMARY BILLING PARTY	SECONDARY BILLING PARTY
INSURANCE CARRIER	INSURANCE CARRIER
ID #	ID #
GROUP #	GROUP #
INSURANCE ADDRESS	INSURANCE ADDRESS
NAME OF INSURED PERSON	NAME OF INSURED PERSON
RELATIONSHIP TO PATIENT	RELATIONSHIP TO PATIENT
EMPLOYER NAME	EMPLOYER NAME
*IF MEDICAID STATE	PHYSICIAN'S PROVIDER #
	WORKERS COMP <input type="checkbox"/> Yes <input type="checkbox"/> No

SPECIMEN INFORMATION	
Collection Date:	Time: <input type="checkbox"/> AM <input type="checkbox"/> PM
Specimen ID #(s):	
Body Site/Descriptor:	
Fixative: <input type="checkbox"/> 10% Neutral Buffered Formalin <input type="checkbox"/> Other:	Hours Fixed:
Specimen Type: <input type="checkbox"/> Fluid: <input type="checkbox"/> Smears: <input type="checkbox"/> Peripheral Blood #	
<input type="checkbox"/> BM Aspirate	<input type="checkbox"/> BM Touch Preps #
<input type="checkbox"/> BM Clot	<input type="checkbox"/> FNA: <input type="checkbox"/> BM Aspirate #
<input type="checkbox"/> BM Core	<input type="checkbox"/> CSF: <input type="checkbox"/> BM Aspirate #
<input type="checkbox"/> Dry Tap	<input type="checkbox"/> Lymph Node: <input type="checkbox"/> Effusion #/Source
<input type="checkbox"/> Peripheral Blood	<input type="checkbox"/> Slides # <input type="checkbox"/> Fresh Tissue #/Site
If Slide Procurement required, indicate below:	
Facility Name:	
Address:	
Phone Number: Fax Number:	

CLINICAL INDICATION FOR STUDY (attach clinical history and pathology reports)		
Narrative Diagnosis/Clinical Data (please include Pathology report with diagnosis, indication for study, and previous test results)		
For pediatric patients ONLY: <input type="checkbox"/> COG Study <input type="checkbox"/> COG Post Treatment		
All diagnoses should be provided by the ordering physician or an authorized designee. Diagnosis/Signs/Symptoms in ICD-CM format in effect at Date of Service (Highest Specificity Required)		
ICD-CM	ICD-CM	ICD-CM
<input type="checkbox"/> Acute Lymphoblastic Leukemia <input type="checkbox"/> B-cell <input type="checkbox"/> T-cell <input type="checkbox"/> Lineage Uncertain	<input type="checkbox"/> Hodgkin Lymphoma <input type="checkbox"/> Leukemia, Unspecified <input type="checkbox"/> Leukocytosis, Unspecified	<input type="checkbox"/> Myelodysplastic Syndrome <input type="checkbox"/> Myeloproliferative Neoplasms <input type="checkbox"/> Non-Hodgkin Lymphoma
<input type="checkbox"/> Acute Myeloid Leukemia <input type="checkbox"/> Anemia	<input type="checkbox"/> Leukopenia <input type="checkbox"/> Lymphadenopathy	<input type="checkbox"/> Polycythemia <input type="checkbox"/> Suspected malignant neoplasm
<input type="checkbox"/> Chronic Lymphocytic Leukemia <input type="checkbox"/> Chronic Myelogenous Leukemia	<input type="checkbox"/> Monoclonal Gammopathy <input type="checkbox"/> Myeloma, Plasma Cell	<input type="checkbox"/> Thrombocytopenia <input type="checkbox"/> Thrombocytosis
Disease Stage/Clinical Course: <input type="checkbox"/> New Diagnosis <input type="checkbox"/> Relapse <input type="checkbox"/> Follow-Up <input type="checkbox"/> Other:		
<input type="checkbox"/> Post Treatment: <input type="checkbox"/> Radiation <input type="checkbox"/> Chemotherapy <input type="checkbox"/> BM Transplantation Donor: <input type="checkbox"/> M <input type="checkbox"/> F		

When ordering tests for which Medicare or Medicaid reimbursements will be sought, physicians should order only those tests that are medically necessary for the diagnosis or treatment of the patient.

Patient, client, and billing information is requested for timely processing of this case. Medicare and other third party payors require that services be medically necessary for coverage, and generally do not cover routine screening tests.

When ordering tests that are subject to ABN guidelines, refer to the policies published by your Medicare Administrative Contractor (MAC), CMS, or www.Labcorp.com/MedicareMedicalNecessity.
Symbols Legend
@ = Subject to Medicare medical necessity guidelines
^ = Medicare deems investigational. Medicare does not pay for services it deems investigational.

- SPECIMEN LABEL INSTRUCTIONS**
1. Complete the requisition with all requested information.
 2. Label specimen with two unique identifiers.
 3. Remove the required number of labels from the front of this sheet.
 4. Place one (1) label on each specimen container (not on the lid).
- Please dispose of unused labels.

Name _____	Name _____	Name _____	Name _____
Name _____	Name _____	Name _____	Name _____

COMPREHENSIVE HEMATOPATHOLOGY ANALYSIS (Peripheral Blood or Bone Marrow)	
<input type="checkbox"/> Comprehensive Evaluation: Morphologic evaluation, Flow Cytometry, Cytogenetics, and Other Relevant Diagnostic and/or Prognostic Tests per Opinion of Reviewing Pathologist (see reverse for prognostic reflex criteria)	
<input type="checkbox"/> Comprehensive Evaluation as above without Cytogenetics	
MORPHOLOGIC EVALUATION (include a copy of CBC report)	
<input type="checkbox"/> Bone Marrow Morphology (with IHC/special stains) <input type="checkbox"/> Peripheral Blood Morphology	
FLOW CYTOMETRY (see reverse for antibody list)	
<input type="checkbox"/> Hematolymphoid Neoplasia Assessment (HNA)	<input type="checkbox"/> BAL CD4:CD8 Assessment ¹
<input type="checkbox"/> Add diagnostic tests per IO Reflex Criteria (see reverse)	<input type="checkbox"/> ZAP70/CD38 Assessment
<input type="checkbox"/> Add prognostic tests per IO Reflex Criteria (see reverse)	<input type="checkbox"/> PNH \blacklozenge
<input type="checkbox"/> DNA Ploidy/S-Phase Assessment	<input type="checkbox"/> Stem Cell Enumeration ¹
<input type="checkbox"/> Leukocyte Adhesion Deficiency Assessment \blacklozenge ¹	<input type="checkbox"/> CLL MRD
	<input type="checkbox"/> ALL MRD (meets COG requirements) ¹ Send to TN
CYTOGENETICS [®]	
<input type="checkbox"/> Cancer Cytogenetics <input type="checkbox"/> Constitutional Cytogenetics [‡]	

FISH (select disease state profile OR individual probes)	
Disease State Profiles (see reverse for panel components)	
<input type="checkbox"/> ALL (Adult) <input type="checkbox"/> ALL (Pediatric) <input type="checkbox"/> AML <input type="checkbox"/> CLL	<input type="checkbox"/> Multiple Myeloma <input type="checkbox"/> MPN/CML <input type="checkbox"/> MPN w/ Eosinophilia <input type="checkbox"/> MDS
Pediatric (COG) <input type="checkbox"/> ALL (Std Risk) <input type="checkbox"/> ALL (High Risk) <input type="checkbox"/> AML	
COG Single Probes <input type="checkbox"/> ABL1 <input type="checkbox"/> ABL2 <input type="checkbox"/> PDGFRb	
Individual Probes (for a complete list of probes visit www.integratedoncology.com)	
<input type="checkbox"/> 5q <input type="checkbox"/> ALK <input type="checkbox"/> BCR/ABL1	
<input type="checkbox"/> If BCR/ABL1 negative, reflex to JAK2 V617F Qual, If JAK2 negative reflex to CALR and MPL	
<input type="checkbox"/> CCND1/IGH, t(11;14)	<input type="checkbox"/> IGH/BCL2, t(14;18) <input type="checkbox"/> IGH/MYC, t(8;14)
<input type="checkbox"/> KM2TA (MLL) <input type="checkbox"/> PML/RARA <input type="checkbox"/> RUNX1/RUNX1T1, t(8;21) <input type="checkbox"/> TCRA/D	<input type="checkbox"/> TP53 (17p-)
Other FISH, specify: _____	

MOLECULAR [®]	
IntelliGEN [®] NGS Assay (see reverse for gene list; bone marrow or peripheral blood)	
<input type="checkbox"/> IntelliGEN [®] Myeloid for AML, MDS, MPN	
Indication: _____	
clonoSEQ [®] NGS MRD Assay [@] for Multiple Myeloma, CLL, B-ALL (Billed by Adaptive Biotechnologies)	
<input type="checkbox"/> clonoSEQ MRD assessment in blood* or bone marrow (Myeloma*, CLL, B-ALL)	
*First test (clonoSEQ ID) for Myeloma patients requires a bone marrow sample.	
Indication: _____	
If diagnosis is not Myeloma, CLL, B-ALL, please complete and submit an ABN, found at www.clonoseq.com/for-clinicians/ordering/	
The patient has (MUST select one option):	
<input type="checkbox"/> had a clonoSEQ ID test.	
<input type="checkbox"/> NOT had a clonoSEQ ID test and the diagnostic sample is at Labcorp Integrated Oncology.	
<input type="checkbox"/> NOT had a clonoSEQ ID test and the diagnostic sample is at (complete slide Procurement in SPECIMEN INFORMATION section of this order form).	

Reveal [®] SNP Microarray* If suspect balanced translocations, run cytogenetics and/or FISH	
<input type="checkbox"/> SNP Microarray for ALL, AML, CLL, MDS and other Hematologic Malignancies	
Indication: _____	
<input type="checkbox"/> FISH + SNP Microarray for Multiple Myeloma	<input type="checkbox"/> SNP Microarray for Multiple Myeloma
If MM(FISH+SNP) is ordered, probes t(4; 14), t(11; 14), t(14; 16) are performed	
Acute Leukemia	Lymphoid Neoplasms
<input type="checkbox"/> FLT3 Mutation	<input type="checkbox"/> B-cell Rearrangement IgH
<input type="checkbox"/> IDH 1/2 Mutation	<input type="checkbox"/> T-cell Rearrangement TRG
<input type="checkbox"/> CEBPA Mutation	<input type="checkbox"/> B-cell Rearrangement IgK
<input type="checkbox"/> NPM1 Mutation	<input type="checkbox"/> T-cell Rearrangement TRB
<input type="checkbox"/> PML/RARA (Quantitative)	<input type="checkbox"/> BCL1 Rearrangement
<input type="checkbox"/> cKIT Mutation	<input type="checkbox"/> BCL2 Rearrangement
<input type="checkbox"/> LeukoStrat [®] CDx	<input type="checkbox"/> IgVH Mutation
<input type="checkbox"/> FLT3 Mutation	<input type="checkbox"/> p53 (CLL/B-cell ONLY)
	<input type="checkbox"/> BRAF Mutation
	<input type="checkbox"/> MYD88 Mutation
	<input type="checkbox"/> BCR/ABL1 Quantitative
	<input type="checkbox"/> ABL Kinase Domain Mutation (BCR/ABL will be run)
	<input type="checkbox"/> JAK2 V617F Mutation, Qual if negative reflex to:
	<input type="checkbox"/> CALR
	<input type="checkbox"/> JAK2 Exon 12-15
	<input type="checkbox"/> MPL 515
	<input type="checkbox"/> JAK2 Exon 12-15 Mutation
	<input type="checkbox"/> MPL 515 Mutation
	<input type="checkbox"/> CALR Mutation
<input type="checkbox"/> Other Molecular, specify: _____	

SPECIAL CHEMISTRY (Serum ONLY)	
Multiple Myeloma Diagnostic: ^{*Meets IMWG Guidelines}	
<input type="checkbox"/> 120256 Immunofixation (sIFE), Protein Electrophoresis (SPE), Quant Free K/λ Light Chains (sFLC) *	
<input type="checkbox"/> 123200 Multiple Myeloma Cascade, SPE Reflex to sIFE and sFLC	
Multiple Myeloma Monitoring:	
<input type="checkbox"/> 001495 sIFE, SPE	<input type="checkbox"/> 001487 SPE
<input type="checkbox"/> 123218 sIFE DARZALEX [®] (daratumumab patients ONLY)	<input type="checkbox"/> 001685 sIFE
<input type="checkbox"/> 121137 sFLC, Quantitative Free Light K/λ Chains plus Ratio	

[‡] Peripheral blood only ¹ clonoSEQ is a registered trademark of Adaptive Biotechnologies www.adaptivebiotech.com
^{*} If sending DNA, the lab only accepts isolated or extracted nucleic acids for which extraction or isolation is performed in an appropriately qualified CLIA or CAP/CMS equivalent laboratory.
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BILLING INFORMATION (attach face sheet and copy of insurance card – both sides)	
Bill: <input type="checkbox"/> My Account <input type="checkbox"/> Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Patient <input type="checkbox"/> Workers Comp	
Patient Hospital Status: <input type="checkbox"/> In-Patient <input type="checkbox"/> Out-Patient <input type="checkbox"/> Non-Patient	
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INSURANCE CARRIER	INSURANCE CARRIER
ID #	ID #
GROUP #	GROUP #
INSURANCE ADDRESS	INSURANCE ADDRESS
NAME OF INSURED PERSON	NAME OF INSURED PERSON
RELATIONSHIP TO PATIENT	RELATIONSHIP TO PATIENT
EMPLOYER NAME	EMPLOYER NAME
*IF MEDICAID STATE	PHYSICIAN'S PROVIDER #
	WORKERS COMP <input type="checkbox"/> Yes <input type="checkbox"/> No

SPECIMEN INFORMATION	
Collection Date:	Time: <input type="checkbox"/> AM <input type="checkbox"/> PM
Specimen ID #(s):	
Body Site/Descriptor:	
Fixative: <input type="checkbox"/> 10% Neutral Buffered Formalin <input type="checkbox"/> Other:	Hours Fixed:
Specimen Type:	Smears:
<input type="checkbox"/> BM Aspirate	<input type="checkbox"/> Fluid:
<input type="checkbox"/> BM Clot	<input type="checkbox"/> FNA:
<input type="checkbox"/> BM Core	<input type="checkbox"/> CSF:
<input type="checkbox"/> Dry Tap	<input type="checkbox"/> Lymph Node:
<input type="checkbox"/> Peripheral Blood	<input type="checkbox"/> Slides #
<input type="checkbox"/> Peripheral Blood	<input type="checkbox"/> Fresh Tissue #/Site
If Slide Procurement required, indicate below:	
Facility Name:	
Address:	
Phone Number:	
Fax Number:	

CLINICAL INDICATION FOR STUDY (attach clinical history and pathology reports)		
Narrative Diagnosis/Clinical Data (please include Pathology report with diagnosis, indication for study, and previous test results)		
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ICD-CM	ICD-CM	ICD-CM
<input type="checkbox"/> Acute Lymphoblastic Leukemia <input type="checkbox"/> B-cell <input type="checkbox"/> T-cell <input type="checkbox"/> Lineage Uncertain	<input type="checkbox"/> Hodgkin Lymphoma <input type="checkbox"/> Leukemia, Unspecified <input type="checkbox"/> Leukocytosis, Unspecified	<input type="checkbox"/> Myelodysplastic Syndrome <input type="checkbox"/> Myeloproliferative Neoplasm <input type="checkbox"/> Non-Hodgkin Lymphoma
<input type="checkbox"/> Acute Myeloid Leukemia <input type="checkbox"/> Anemia	<input type="checkbox"/> Leukopenia <input type="checkbox"/> Lymphadenopathy	<input type="checkbox"/> Polycythemia <input type="checkbox"/> Suspected malignant neoplasm
<input type="checkbox"/> Chronic Lymphocytic Leukemia <input type="checkbox"/> Chronic Myelogenous Leukemia	<input type="checkbox"/> Monoclonal Gammopathy <input type="checkbox"/> Myeloma, Plasma Cell	<input type="checkbox"/> Thrombocytopenia <input type="checkbox"/> Thrombocytosis
Disease Stage/Clinical Course: <input type="checkbox"/> New Diagnosis <input type="checkbox"/> Relapse <input type="checkbox"/> Follow-Up <input type="checkbox"/> Other:		
<input type="checkbox"/> Post Treatment: <input type="checkbox"/> Radiation <input type="checkbox"/> Chemotherapy <input type="checkbox"/> BM Transplantation Donor: <input type="checkbox"/> M <input type="checkbox"/> F		

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Symbols Legend
@ = Subject to Medicare medical necessity guidelines
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SPECIMEN LABEL INSTRUCTIONS

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4. Place one (1) label on each specimen container (not on the lid).

Please dispose of unused labels.

COMPREHENSIVE HEMATOPATHOLOGY ANALYSIS (Peripheral Blood or Bone Marrow)	
<input type="checkbox"/> Comprehensive Evaluation: Morphologic evaluation, Flow Cytometry, Cytogenetics, and Other Relevant Diagnostic and/or Prognostic Tests per Opinion of Reviewing Pathologist (see reverse for prognostic reflex criteria)	
<input type="checkbox"/> Comprehensive Evaluation as above without Cytogenetics	
MORPHOLOGIC EVALUATION (include a copy of CBC report)	
<input type="checkbox"/> Bone Marrow Morphology (with IHC/special stains)	<input type="checkbox"/> Peripheral Blood Morphology
FLOW CYTOMETRY (see reverse for antibody list)	
<input type="checkbox"/> Hematolymphoid Neoplasia Assessment (HNA)	<input type="checkbox"/> BAL CD4:CD8 Assessment ¹
<input type="checkbox"/> Add diagnostic tests per IO Reflex Criteria (see reverse)	<input type="checkbox"/> ZAP70/CD38 Assessment
<input type="checkbox"/> Add prognostic tests per IO Reflex Criteria (see reverse)	<input type="checkbox"/> PNH \blacklozenge
<input type="checkbox"/> DNA Ploidy/S-Phase Assessment	<input type="checkbox"/> Stem Cell Enumeration ¹
<input type="checkbox"/> Leukocyte Adhesion Deficiency Assessment \blacklozenge ¹	<input type="checkbox"/> CLL MRD
	<input type="checkbox"/> ALL MRD (meets COG requirements) ¹ Send to TN
CYTOGENETICS [®]	
<input type="checkbox"/> Cancer Cytogenetics	<input type="checkbox"/> Constitutional Cytogenetics [‡]
FISH (select disease state profile OR individual probes)	
Disease State Profiles (see reverse for panel components)	
<input type="checkbox"/> ALL (Adult)	<input type="checkbox"/> ALL (Pediatric)
<input type="checkbox"/> Multiple Myeloma	<input type="checkbox"/> MPN/CML
<input type="checkbox"/> AML	<input type="checkbox"/> MPN w/ Eosinophilia
<input type="checkbox"/> CLL	<input type="checkbox"/> MDS
Pediatric (COG)	
<input type="checkbox"/> ALL (Std Risk)	<input type="checkbox"/> ALL (High Risk)
<input type="checkbox"/> AML	<input type="checkbox"/> PDGFRb
COG Single Probes	
<input type="checkbox"/> ABL1	<input type="checkbox"/> ABL2
Individual Probes (for a complete list of probes visit www.integratedoncology.com)	
<input type="checkbox"/> 5q	<input type="checkbox"/> ALK
<input type="checkbox"/> BCR/ABL1	<input type="checkbox"/> If BCR/ABL1 negative, reflex to JAK2 V617F Qual, If JAK2 negative reflex to CALR and MPL
<input type="checkbox"/> CCND1/IGH, t(11;14)	<input type="checkbox"/> IGH/BCL2, t(14;18)
<input type="checkbox"/> IGH/MYC, t(8;14)	<input type="checkbox"/> KM2TA (MLL)
<input type="checkbox"/> PML/RARA	<input type="checkbox"/> RUNX1/RUNX1T1, t(8;21)
<input type="checkbox"/> TP53 (17p-)	<input type="checkbox"/> TCRA/D
Other FISH, specify: _____	

MOLECULAR [®]	
IntelliGEN[®] NGS Assay (see reverse for gene list; bone marrow or peripheral blood)	
<input type="checkbox"/> IntelliGEN [®] Myeloid for AML, MDS, MPN	
Indication: _____	
clonoSEQ[®] NGS MRD Assay[@] for Multiple Myeloma, CLL, B-ALL (Billed by Adaptive Biotechnologies)	
<input type="checkbox"/> clonoSEQ MRD assessment in blood* or bone marrow (Myeloma*, CLL, B-ALL)	
*First test (clonoSEQ ID) for Myeloma patients requires a bone marrow sample.	
Indication: _____	
If diagnosis is not Myeloma, CLL, B-ALL, please complete and submit an ABN, found at www.clonoseq.com/for-clinicians/ordering/	
The patient has (MUST select one option):	
<input type="checkbox"/> had a clonoSEQ ID test.	
<input type="checkbox"/> NOT had a clonoSEQ ID test and the diagnostic sample is at Labcorp Integrated Oncology.	
<input type="checkbox"/> NOT had a clonoSEQ ID test and the diagnostic sample is at (complete slide Procurement in SPECIMEN INFORMATION section of this order form).	

Reveal [®] SNP Microarray [‡] If suspect balanced translocations, run cytogenetics and/or FISH	
<input type="checkbox"/> SNP Microarray for ALL, AML, CLL, MDS and other Hematologic Malignancies	
Indication: _____	
<input type="checkbox"/> FISH + SNP Microarray for Multiple Myeloma <input type="checkbox"/> SNP Microarray for Multiple Myeloma	
If MM(FISH+SNP) is ordered, probes t(4;14), t(11;14), t(14;16) are performed	
Acute Leukemia	Lymphoid Neoplasms
<input type="checkbox"/> FLT3 Mutation	<input type="checkbox"/> B-cell Rearrangement IgH
<input type="checkbox"/> IDH 1/2 Mutation	<input type="checkbox"/> T-cell Rearrangement TRG
<input type="checkbox"/> CEBPA Mutation	<input type="checkbox"/> B-cell Rearrangement IgK
<input type="checkbox"/> NPM1 Mutation	<input type="checkbox"/> T-cell Rearrangement TRB
<input type="checkbox"/> PML/RARA (Quantitative)	<input type="checkbox"/> BCL1 Rearrangement
<input type="checkbox"/> cKIT Mutation	<input type="checkbox"/> BCL2 Rearrangement
<input type="checkbox"/> LeukoStrat [®] CDx	<input type="checkbox"/> IgVH Mutation
<input type="checkbox"/> FLT3 Mutation	<input type="checkbox"/> p53 (CLL/B-cell ONLY)
	<input type="checkbox"/> BRAF Mutation
	<input type="checkbox"/> MYD88 Mutation
MPN/CML	
<input type="checkbox"/> BCR/ABL1 Quantitative	
<input type="checkbox"/> ABL Kinase Domain Mutation (BCR/ABL will be run)	
<input type="checkbox"/> JAK2 V617F Mutation, Qual if negative reflex to:	
<input type="checkbox"/> CALR	
<input type="checkbox"/> JAK2 Exon 12-15	
<input type="checkbox"/> MPL 515	
<input type="checkbox"/> JAK2 Exon 12-15 Mutation	
<input type="checkbox"/> MPL 515 Mutation	
<input type="checkbox"/> CALR Mutation	
<input type="checkbox"/> Other Molecular, specify: _____	

SPECIAL CHEMISTRY (Serum ONLY)	
Multiple Myeloma Diagnostic: ^{*Meets IMWG Guidelines}	
<input type="checkbox"/> 120256 Immunofixation (sIFE), Protein Electrophoresis (SPE), Quant Free K/ Λ Light Chains (sFLC) *	
<input type="checkbox"/> 123200 Multiple Myeloma Cascade, SPE Reflex to sIFE and sFLC	
Multiple Myeloma Monitoring:	
<input type="checkbox"/> 001495 sIFE, SPE	<input type="checkbox"/> 001487 SPE
<input type="checkbox"/> 123218 sIFE DARZALEX [®] (daratumumab patients ONLY)	<input type="checkbox"/> 001685 sIFE
<input type="checkbox"/> 121137 sFLC, Quantitative Free Light K/ Λ Chains plus Ratio	

\blacklozenge Peripheral blood only
*If sending DNA, the lab only accepts isolated or extracted nucleic acids for which extraction or isolation is performed in an appropriately qualified CLIA or CAP/CMS equivalent laboratory.
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B2A

Prognostic Test Reflex Criteria			
Disease Category	Timing	Findings (Morphology, Flow cytometry, FISH and/or karyotyping)	Tests to Perform
ALL	Initial Diagnosis	ALL	Pediatric FISH Profile (<22 years) or Adult FISH Profile (>22 years); Reveal [®] SNP Array
AML	Initial Diagnosis	AML or borderline AML	FISH probes for RUNX1T1/RUNX1 t(8;21), CBFB inv(16), or PML/RARA t(15;17) or MLL respectively, as indicated; NGS myeloid panel + FLT3 testing for patients <60 years; discuss necessity of testing with client or place comment in report for patients >= 60 years
AML	Relapse	Findings indicative of relapse	NGS myeloid panel <60 years; discuss necessity of testing with client or place comment in report for patients >= 60 years
CLL (peripheral blood/bone marrow)	Initial Diagnosis	CD5+ neoplasm with classic or variant CLL features; >5K/uL circulating monoclonal B-cells or 10% or more marrow based monoclonal B-cells	CLL FISH profile or CLL SNP array with FISH probe for CCND1/IGH t(11;14), ZAP70/CD38 assay, and IgVH mutation analysis
CLL (peripheral blood/bone marrow)	Follow-up*	Features of refractory disease or disease progression/transformation	FISH probe for TP53 (17p-) deletion, TP53 mutation analysis, and SNP array
CML	Initial Diagnosis	Compatible or diagnostic findings for CML	Quantitative BCR/ABL1 assay and cytogenetics
CML	Follow-up*	Prior diagnosis of CML	Quantitative BCR/ABL1 assay; if features of progression, discuss addition of NGS myeloid panel with client or place comment in report
MPN	Initial Diagnosis	Morphologic features of MPN, but negative for JAK2 V617F, CALR, and MPL mutations	NGS myeloid panel for patients <60 years; discuss necessity of testing with client or place comment in report for patients >= 60 years
MPN	Follow-up*	History of MPN, currently with features of progression (increased blasts or dysplastic features)	Discuss addition of NGS myeloid panel with client or place comment in report
MDS	Initial Diagnosis	Morphologic diagnosis of MDS with normal cytogenetic karyotype	NGS myeloid panel for patients <60 years; discuss necessity of testing with client or place comment in report for patients >= 60 years
Plasma cell neoplasia	Initial Diagnosis	5% or more neoplastic plasma cells by morphology or 1% or more by flow cytometry	Myeloma FISH profile
Plasma cell neoplasia	Follow-up*	Features of disease progression	FISH probes for TP53 (17p-), CKS1B (1q21), Monosomy 1
SLL	Initial Diagnosis	SLL identified in tissue sample by flow cytometry with 10% or more neoplastic cells	CLL FISH profile or CLL SNP array with FISH probe for CCND1/IGH t(11;14), IgVH mutation analysis

*recommendation for follow-up evaluation requires that prior material was evaluated in an IO facility

Diagnostic Test Reflex Criteria Based on Flow Cytometry or Surgical Pathology Consultation Findings			
Disease Category	Timing	Findings	Tests to Perform
AML	Initial Diagnosis	Diagnostic or suspicious for AML with RUNX1T1/RUNX1 t(8;21), CBFB inv (16), or PML/RARA t(15;17), acute myelomonocytic, or acute monocytic/monoblastic leukemia	FISH probes for RUNX1T1/RUNX1 t(8;21), CBFB inv(16), or PML/RARA t(15;17) or MLL respectively, as indicated; NGS myeloid panel + FLT3 testing for patients <60 years; discuss necessity of testing with client or place comment in report for patients >= 60 years
B-cell lymphoma	Initial Diagnosis	Findings suspicious or diagnostic for B-cell lymphoma, but with equivocal findings with regard to subclassification (for tissue cases 5% or more abnormal B-cells by flow cytometry; for peripheral blood/bone marrow cases, 10% or more abnormal B-cells)	NHL FISH probes and molecular assays as indicated
Large B-cell lymphoma or Burkitt lymphoma	Initial Diagnosis	Abnormal B-cells diagnostic or suspicious for large B-cell lymphoma or Burkitt lymphoma	FISH probes for MYC, BCL6, and BCL2 translocations and cytogenetic karyotyping, as indicated; reflex to 11q FISH probe (BCL1 and ATM) for MYC, BCL6, BCL2 negative cases suspicious for Burkitt lymphoma, as indicated
Eosinophilia	Initial Diagnosis	Peripheral blood with 1.0K/uL or more eosinophils	FISH probes for PDGFRA, PDGFRB, and FGFR1
Hairy Cell Leukemia (HCL)	Initial Diagnosis	CD103+ monoclonal B-cells (5% or more) inconclusive for HCL	BRAF mutation
Lymphoplasmacytic Lymphoma (LPL)	Initial Diagnosis	Monoclonal B-cells (10% or more) with features indicating LPL in differential diagnosis	MYD88 mutation
Mantle cell lymphoma (MCL)	Initial Diagnosis	Monotypic B-cells (5% or more) diagnostic or suspicious of MCL	FISH probe for CCND1/IGH t(11;14)
Mastocytosis	Initial Diagnosis	Atypical mast cells by flow cytometry	c-KIT mutation analysis for mast cell disease
CML	Initial Diagnosis	Flow cytometric findings suspicious for CML	FISH for BCR/ABL1
MDS/MPN	Initial Diagnosis	Findings suspicious for MDS/MPN (CMML, aCML, etc.)	NGS myeloid panel for patients <60 years; discuss necessity of testing with client or place comment in report for patients >= 60 years
T-cell lymphoma/leukemia	Initial Diagnosis	Atypical T-cells diagnostic or suspicious for T-cell lymphoma/leukemia	TCR gene rearrangement ; ALK FISH probe for CD30+ cases, as indicated; cytogenetic karyotyping if material adequate

[†]LeukoStrat[®] CDx FLT3 Mutation performed by The Laboratory for Personalized Molecular Medicine (LabPMM[®])
[‡]Informed consent is required for non-oncology genetics testing for New York state patients.

Morphologic Evaluation Common Components (Please include patient CBC report)		
• Peripheral Blood Interpretation (85060) • Clot (88305)	• Core (88305)	• Additional Studies/Special Stains (88313) – Iron and Reticulin
• Bone Marrow Aspirate Smear & Interpretation (85097)	• Decalcification (88311)	• IHC Global marker number (88342) varies but typically 0-4

Flow Cytometry*		
Peripheral blood/bone marrow panel (HNA) 24 *□ antibodies CD2, CD3, CD4, CD5, CD7, CD8, CD10, CD11b, CD13, CD14, CD16, CD19, CD20, CD23, CD57, CD33, CD34, CD38, CD45, CD56, CD64, HLA-DR, kappa light chain, lambda light chain	Tissue/fluids panel (HNA) 19 *□ antibodies CD2, CD3, CD4, CD5, CD7, CD8, CD10, CD11c, CD13 or CD33, CD19, CD20, CD22, CD23, CD38, CD45, CD56, CD71, kappa light chain, lambda light chain	PNH Evaluation CD14, CD15, CD24, CD45, CD64, FLAER. CD59 and CD235a may be added at discretion of reviewing pathologist

*Additional antibodies may be added if determined to be medically necessary to render a diagnosis in the opinion of the reviewing pathologist. □ Markers performed determined by testing facility.

FISH/TARGETGENE [®] (disease state profile OR individual probes)						
ALL (Adult) BCR/ABL1, t(9;22) KMT2A (MLL) MYC 6 21q	ALL (Pediatric) BCR/ABL1,t(9;22) 4 10 17 KMT2A (MLL) CDKN2A (p16) TCF3 (E2A) ETV6/RUNX1, t(12;21)	AML PML/RARA, t(15;17) CBFB, inv(16) RUNX1T1/RUNX1, t(8;21) 5q 7q KMT2A (MLL)	CLL TP53 (17p-) ATM (11q-) CCND1/IGH, t(11;14) 13q14 (DLEU) 12	MPN/CML 20q 8 9 13q14 (DLEU) BCR/ABL1, t(9;22)	Multiple Myeloma Monosomy 13/13q- TP53 (17p-) 7 9 15 CCND1/IGH, t(11;14) CKS1B (1q21) FGFR3/GH, t(4;14) IGH/MAF, t(14;16)	NHL ALK BCL6 CCND1/IGH, t(11;14) IGH/BCL2, t(14;18) IGH/MYC, t(8;14) MALT1 TCR/VD
		Aggressive B-cell Lymphoma BCL2 BCL6 MYC	MDS 5q 7q 20q 8	MPN with Eosinophilia FGFR1 PDGFRA PDGFRB		

SERUM - Multiple Myeloma Cascade, Protein Electrophoresis (SPE) reflex to Immunofixation (sIFE) and Free Light Chain (sFLC)
for interpretation, refer to www.Labcorp.com

IntelliGEN[®] (for genes evaluated, refer to www.integratedoncology.com)

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 LeukoStrat[®] is a registered trademark of Invivoscribe Technologies, Inc.
 Integrated Oncology is a brand used by both Accupath Diagnostic Laboratories, Inc. and Esoterix Genetic Laboratories, LLC, wholly-owned subsidiaries of Laboratory Corporation of America[®] Holdings.
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 onc-7111N-v14-03022021

Lab Locations		
Accupath Diagnostic Laboratories, Inc.		Esoterix Genetic Laboratories, LLC
201 Summit View Drive, Suite 100 Brentwood, TN 37027	5005 South 40th Street Phoenix, AZ 85040	3 Forest Parkway Shelton, CT 06484