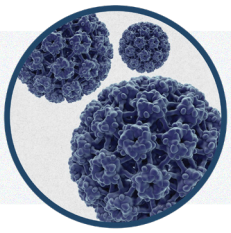
NavDx
Optimizing HPV+ Cancer Care



Guide to the NavDx® Test Requisition Form (TRF)

1 Required Fields

Complete all fields in Ordering Healthcare Provider, Patient Information, Mobile Phlebotomy, Clinical Information, and Billing Information sections. *Remember to include **Medical Record Number** in Patient Information section.*

2 Offsite or Mobile Phlebotomy

Indicate if the NavDx team should work with the patient to coordinate blood draws at a nearby walk-in clinic or at their home or workplace via our mobile phlebotomy network.

3 ICD-10 Code(s)

Provide an ICD-10 code(s) that matches the diagnosis and supports the reason for testing. ***Required for Surveillance patients:*** *Select a 'History of' Z-Code.*

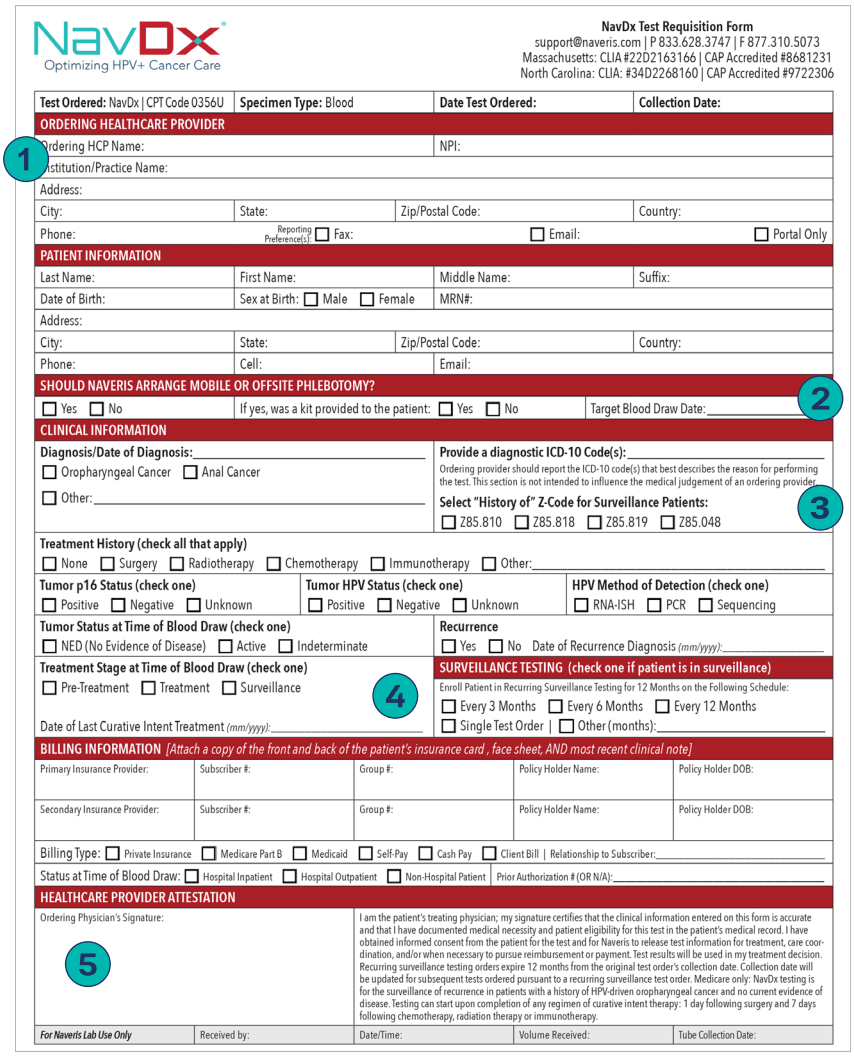
4 Treatment Stage

Choose **one** Treatment Stage. For **Surveillance** also choose one option under **Surveillance Testing**:

1. A testing cadence. Any of these options enrolls the patient in our **Surveillance Testing Program**, which automatically schedules orders at your chosen cadence for the following 12 months. You will receive reminders when patients' testing windows are approaching.
2. Single Test Order for one-time testing.

5 Healthcare Provider Attestation

Ordering provider signature is **required**. *Recurring orders expire 12 months from original collection date.*



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NavDx Test Requisition Form
support@naveris.com | P 833.628.3747 | F 877.310.5073
Massachusetts: CLIA #22D2163166 | CAP Accredited #8681231
North Carolina: CLIA: #34D2268160 | CAP Accredited #9722306

Test Ordered: NavDx | CPT Code 0356U	Specimen Type: Blood	Date Test Ordered:	Collection Date:

ORDERING HEALTHCARE PROVIDER (1)

Ordering HCP Name:		NPI:	
Institution/Practice Name:			
Address:			
City:	State:	Zip/Postal Code:	Country:
Phone:	Reporting Preference(s): ☐ Fax:	☐ Email:	☐ Portal Only

PATIENT INFORMATION

Last Name:	First Name:	Middle Name:	Suffix:
Date of Birth:	Sex at Birth: ☐ Male ☐ Female	MRN#:	
Address:			
City:	State:	Zip/Postal Code:	Country:
Phone:	Cell:	Email:	

SHOULD NAVERIS ARRANGE MOBILE OR OFFSITE PHLEBOTOMY? (2)

☐ Yes ☐ No	If yes, was a kit provided to the patient: ☐ Yes ☐ No	Target Blood Draw Date: _____

CLINICAL INFORMATION

Diagnosis/Date of Diagnosis: _____
☐ Oropharyngeal Cancer ☐ Anal Cancer
☐ Other: _____

Provide a diagnostic ICD-10 Code(s): _____
Ordering provider should report the ICD-10 code(s) that best describes the reason for performing the test. This section is not intended to influence the medical judgement of an ordering provider.
Select "History of" Z-Code for Surveillance Patients: (3)
☐ Z85.810 ☐ Z85.818 ☐ Z85.819 ☐ Z85.048

Treatment History (check all that apply)
☐ None ☐ Surgery ☐ Radiotherapy ☐ Chemotherapy ☐ Immunotherapy ☐ Other: _____

Tumor p16 Status (check one)	Tumor HPV Status (check one)	HPV Method of Detection (check one)
☐ Positive ☐ Negative ☐ Unknown	☐ Positive ☐ Negative ☐ Unknown	☐ RNA-ISH ☐ PCR ☐ Sequencing

Tumor Status at Time of Blood Draw (check one)
☐ NED (No Evidence of Disease) ☐ Active ☐ Indeterminate

Recurrence
☐ Yes ☐ No Date of Recurrence Diagnosis (mm/yyyy): _____

Treatment Stage at Time of Blood Draw (check one)
☐ Pre-Treatment ☐ Treatment ☐ Surveillance (4)
Date of Last Curative Intent Treatment (mm/yyyy): _____

SURVEILLANCE TESTING (check one if patient is in surveillance)
Enroll Patient in Recurring Surveillance Testing for 12 Months on the Following Schedule:
☐ Every 3 Months ☐ Every 6 Months ☐ Every 12 Months
☐ Single Test Order | ☐ Other (months): _____

BILLING INFORMATION *[Attach a copy of the front and back of the patient's insurance card , face sheet, AND most recent clinical note]*

Primary Insurance Provider:	Subscriber #:	Group #:	Policy Holder Name:	Policy Holder DOB:
Secondary Insurance Provider:	Subscriber #:	Group #:	Policy Holder Name:	Policy Holder DOB:

Billing Type: ☐ Private Insurance ☐ Medicare Part B ☐ Medicaid ☐ Self-Pay ☐ Cash Pay ☐ Client Bill | Relationship to Subscriber: _____
Status at Time of Blood Draw: ☐ Hospital Inpatient ☐ Hospital Outpatient ☐ Non-Hospital Patient | Prior Authorization # (OR N/A): _____

HEALTHCARE PROVIDER ATTESTATION

Ordering Physician's Signature: (5)

I am the patient's treating physician; my signature certifies that the clinical information entered on this form is accurate and that I have documented medical necessity and patient eligibility for this test in the patient's medical record. I have obtained informed consent from the patient for the test and for Naveris to release test information for treatment, care coordination, and/or when necessary to pursue reimbursement or payment. Test results will be used in my treatment decision. Recurring surveillance testing orders expire 12 months from the original test order's collection date. Collection date will be updated for subsequent tests ordered pursuant to a recurring surveillance test order. Medicare only: NavDx testing is for the surveillance of recurrence in patients with a history of HPV-driven oropharyngeal cancer and no current evidence of disease. Testing can start upon completion of any regimen of curative intent therapy: 1 day following surgery and 7 days following chemotherapy, radiation therapy or immunotherapy.

For Naveris Lab Use Only	Received by:	Date/Time:	Volume Received:	Tube Collection Date:

Need Assistance?

Our Clinical Operations Team is available to help.

833-628-3747 | clinops@naveris.com
Monday–Friday, 9am–8pm Eastern

SCAN or CLICK!

Learn more about Ordering NavDx

Explore how to Implement NavDx

CareDx

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