ProMark® Prognostic Assay: REQUEST FORM

Please perform the following test for the patient listed below:

☐ **ProMark**

Date:	
Physician name:	Physician fax:

I authorize testing and confirm: 1) that this test is medically necessary and the results will be used in the medical management and treatment decisions for the patient; 2) that informed consent has been obtained; and 3) that I have on file the patient's assignment of benefits authorizing insurance benefits to be paid to Metamark Genetics, Inc. (Metamark). I authorize Metamark to contact the patient, if necessary, for testing authorization and discussion of financial responsibility. I authorize Metamark to release the information on this form and other information provided by me that is necessary to process a claim for this service.

Physician signature (REQUIRED):

FACILITY NAME AND ADDRESS: *(Please complete if this field is empty)*

Please send copies of final report to: *(optional)*	Name:	Fax #:

PATIENT INFORMATION *(Please complete ALL fields)*

Patient name:	Accession #/Case #:	
Patient date-of-birth:	Patient phone:	
Patient address:	City:	State:

Please include the following from each site of interest:

- ✓ Tissue from the highest Gleason Score overall (3+3 or 3+4)
  - Please submit **5 slides, 5 µm per slide**, from 2 qualifying sites when possible
  - Please do not include sites with 100% tumor involvement
- ✓ Prostate biopsy pathology report
- ✓ Patient demographic information

CLINICAL INFORMATION

Diagnosis Code: ☐ C61: Prostate Cancer *(185)* ☐ Other:		**Biopsy Gleason:** ☐ 3+3 ☐ 3+4	
Clinical Stage: ☐ T1a ☐ T1b ☐ T1c ☐ T2a ☐ T2b ☐ T2c	**Total # cores:**	**Total # cores positive:**	**Pre-Biopsy PSA:**

INSURANCE INFORMATION

Bill to: ☐ Insurance ☐ Medicare ☐ Medicaid ☐ Patient/Self-Pay

PRIMARY INSURANCE	Policy #:
Plan name:	Group #:
Name of subscriber:	Patient relationship to subscriber:
SECONDARY INSURANCE	Policy #:
Plan name:	Group #:

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