AVISE® Test Requisition

Provider Relations: 888.452.1522

AVISE® Objective Testing Accurate Treatment

STEP 1 Patient & Provider Information *(Required)*

Patient Details

Full Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ ☐ Male ☐ Female

DOB: ____ /____ /____ MRN: _____

Attach a copy of front and back of insurance cards

BILLING INFORMATION: ☐ Insurance ☐ Patient ☐ Lab

MEDICARE only Hospital: ☐ Non-hospital patient ☐ In-patient ☐ Out-patient

Provider Details

Provider Name: _____

NPI #: _____

Practice Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Lab Name: _____ Zip: _____

☐ Fax results to Lab. Fax #

STEP 2 Diagnosis: ICD-10 Codes *(Required)*

Provide ICD-10 Diagnosis Codes (highest level of specificity) that are medically appropriate for the patient's condition and consistent with the patient's medical record.

ICD-10 CODES *(Required)*: _____/ _____/_____/_____/_____

STEP 3 Test Order and Specimen Information

Date Specimen(s) Collected: *(required)* ____/____/____ **Time of collection:** _____

☐ AVISE CTD

10 mL whole blood EDTA (lavender tube)
5 mL serum SST (tiger top tube)

AVISE Lupus (included with AVISE CTD)

- ☐ **ENA**
  - ☐ U1RNP
  - ☐ RNP70
  - ☐ Ro52
  - ☐ Ro60
  - ☐ RNA Pol III
- ☐ **Thyroid**
  - ☐ TPO
  - ☐ TG
- ☐ **RA**
  - ☐ RF IgM
  - ☐ RF IgA
- ☐ **APS**
  - ☐ aCL
    - ☐ IgG
    - ☐ IgM
  - ☐ β2 GP1
    - ☐ IgG
    - ☐ IgM

☐ Add **AVISE SLE Prognostic** if AVISE Index is POSITIVE

☐ AVISE Anti-CarP

5 mL serum SST (tiger top tube)

☐ Anti-Histone

5 mL serum SST (tiger top tube)

☐ AVISE Lupus

10 mL whole blood EDTA (lavender tube)
5 mL serum SST (tiger top tube)

AVISE Lupus consists of 10 analytes, including 2 CB-CAPs (EC4d & BC4d) and 8 autoantibodies (ANA, anti-dsDNA, anti-Smith, anti-CCP, anti-Centromere protein B, anti-Jo-1, anti-Scl70, and anti-SSB/La), to aid the differential diagnosis of Lupus.

☐ Add **AVISE SLE Prognostic** if AVISE Index is POSITIVE

☐ AVISE APS

5 mL serum SST (tiger top tube)

- ☐ aCL
  - ☐ IgG
  - ☐ IgM
  - ☐ IgA
- ☐ β2 GP1
  - ☐ IgG
  - ☐ IgM
  - ☐ IgA
- ☐ PS/PT
  - ☐ IgG
  - ☐ IgM

☐ AVISE SLE Prognostic

5 mL serum SST (tiger top tube)

- ☐ C1q
- ☐ Ribosomal P
- ☐ PS/PT
  - ☐ IgG
  - ☐ IgM
- ☐ aCL
  - ☐ IgG
  - ☐ IgM
  - ☐ IgA
- ☐ β2 GP1
  - ☐ IgG
  - ☐ IgM
  - ☐ IgA

☐ AVISE SLE Monitor

10 mL whole blood EDTA (lavender tube)
5 mL serum SST (tiger top tube)

- ☐ EC4d
- ☐ C1q
- ☐ dsDNA CIA
- ☐ PC4d
- ☐ C3
- ☐ C4

☐ Include **AVISE HCQ**
Current dose: _____**mg/day**
Specimen should be collected at least 4 hours after last dose

☐ Include **AVISE MTX**
Current dose: _____ **mg/week**

☐ AVISE Vasculitis-AAV

5 mL serum SST (tiger top tube)

- ☐ Anti-PR3
- ☐ Anti-GBM
- ☐ Anti-MPO
- ☐ ANCA (IFA)

☐ AVISE MTX

5 mL whole blood EDTA (lavender tube)
Current dose:_____ **mg/week**

☐ Injection Or
☐ Number of pills/week

☐ AVISE HCQ

5 mL whole blood EDTA (lavender tube)
Current dose: _____ **mg/day**

Specimen should be collected at least 4 hours after last dose

In the event test orders contain overlapping analytes, those analytes will be reported on each test report but will not be performed more than once.

STEP 4 Medically Necessary

I certify that the ordered test(s) is(are) reasonable and medically necessary for the diagnosis, care, and treatment of this patient's condition.

Physician signature: _____ Date: _____

Print Name:_____

LM1058 (08/22)

AVISE Specimen Requirements

Order Type	Tube Requirements
Up to 2 AVISE tests	**one**- 10 mL whole blood EDTA (lavender tube) **one**- 5 mL serum SST (tiger top tube)
3 or more AVISE tests	**two**- 10 mL whole blood EDTA (lavender tubes) **one**- 5 mL serum SST (tiger top tube)

AVISE Specimen Submission

PREPARE SPECIMEN COLLECTION KIT FOR SHIPPING:

Ship specimens Monday through Friday on same day blood is drawn, priority overnight delivery, using pre-printed shipping label.

1. Insert frozen cold pack in one of the cooler wells.
2. Enclose specimen(s) in Bio-Hazard specimen bag and place bag inside the alternate well, away from the cold pack. **Specimens from multiple patients may be included in the same box.**
3. Replace foam cooler lid and place the completed test requisition(s) and insurance card copies on top of cooler before closing outer transportation kit box.
4. **Place kit inside plastic carrier bag and affix shipping label to bag.**
5. **Contact carrier indicated on the prepaid shipping label for pick-up or call Exagen Provider Relations at 888.452.1522 for assistance.**

QUESTIONS?

Call **888.452.1522** or visit **www.AviseTest.com** or email shipping@exagen.com to place a kit order.

Exagen®

AVISE® tests are used for clinical purposes; the results provided are not intended to be used as the sole means for clinical diagnosis or patient management decisions. AVISE tests were developed and performance characteristics were determined by Exagen as Laboratory Developed Tests (LDTs). The Exagen laboratory is certified under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) and accredited by the College of American Pathologists (CAP) as qualified to perform high-complexity clinical laboratory testing. AVISE tests have not been cleared or approved by the U.S. Food and Drug Administration (FDA).

Exagen Inc. | 1261 Liberty Way | Vista, California 92081
Tel: 888.452.1522 | Fax: 888.452.8344 | www.AviseTest.com

AVISE® Access

QUALIFICATION FORM

Available at: AviseTest.com/Access

SCAN + QUALIFY

PATIENT INFORMATION

Last Name	First Name	Zip Code

Date of Birth	Phone Number	Email Address
/ /		

I choose to OPT-OUT of receiving e-mail correspondence regarding my AVISE test: ☐ Yes

ANSWER YES TO QUESTION A, B OR C, AND YOU AUTOMATICALLY QUALIFY FOR AN OUT OF POCKET COST OF $45 PER TEST†.

A. If you are not working, did you become unemployed within the past 12 months? ☐ Yes ☐ No

B. Did your medical expenses exceed 10% of your gross household income or $6,380 for the last calendar year? ☐ Yes ☐ No

C. Based on the table below, is your household annual gross income less than the amount corresponding with the number of persons in your household? ☐ Yes ☐ No

Persons in household	1	2	3	4	5	6	7	8*
Annual gross income	$67,950	$91,550	$115,150	$138,750	$162,350	$185,950	$209,550	$233,150

*If your household has more than 8 persons, please contact the Patient Advocate Team at 1-888-452-1522 (select option 2).

☐ Check here if you do not qualify based on A, B or C above, or if you believe the $45 is still a hardship, and the Patient Advocate Team will contact you about qualifying through additional methods.††

I hereby acknowledge that the above information is true and correct according to the best of my knowledge. I understand that if I do not qualify, I will be notified and Exagen Inc. will bill me. I hereby acknowledge that I am neither related to nor employed by the physician who ordered the testing.

Name _____ Signature _____ Date _____

Please send your completed form to: **Exagen Inc., AVISE Access, 1261 Liberty Way, Vista, CA 92081**
Every effort will be made to process your form expeditiously.

Have questions? Call our Patient Advocate Team at: **1-888-452-1522** (select option 2)

Exagen® *Patient Focused. Discovery Driven.*

†Excludes Medicaid, Medicare. ††Additional methods may require supporting documentation.

AVISE®

ADVANCE PATIENT NOTIFICATION (APN)

Do not use for Medicare/Medicaid/Tricare Patients

LAB USE ONLY

Date of Service

PLEASE SUBMIT THIS FORM WITH YOUR AVISE TEST REQUISITION

Your physician ordered AN INNOVATIVE AVISE BLOOD TEST for you FROM EXAGEN INC.

By signing below, I acknowledge and understand that I will be responsible for any out of network and/or out of pocket costs.

I authorize Exagen Inc. to pursue all necessary appeals for payment on my behalf with my health insurance company in relation to services provided. If my health insurance company sends payment to me, I agree to pay Exagen Inc. in full the amount of such payment.

Patient Name (Print)

Phone Number

Expiration Date of Authorization
(if other than 24 months)

Patient (Parent/Guardian) Signature

Date

POR FAVOR, PRESENTE ESTE FORMULARIO CON SU SOLICITUD DE LA PRUEBA AVISE

Su médico ordenó EL INNOVADOR ANÁLISIS DE SANGRE AVISE, de la empresa EXAGEN INC.

Al firmar este formulario, reconozco y comprendo que seré responsable de cualquier costo fuera de la red de mi seguro de salud asi como cualquier pago adicional.

Autorizo a Exagen Inc. para que persiga todas las apelaciones necesarias para el pago de los servicios brindados, en mi nombre, con mi compañia de seguro de salud. Si mi compañia de seguro de salud me envía el pago, yo se lo enviaré a Exagen Inc. por completo.

Nombre del Paciente (en Letra de Molde)

Número de Teléfono

Fecha de Vencimiento de la Autorización
(si no es de 24 meses)

Firma del Paciente (Padre/Tutor)

Fecha

Have questions? Call our Patient Advocate Team at: **1-888-452-1522** (select option 2)

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