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: _____

DOB: ____ / ____ / ____ MRN: _____

Birth Sex: ☐ Male ☐ Female ☐ Undisclosed/Unspecified

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:** _____ **Collected by (full name):** _____

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

☐ AVISE SLE Prognostic

5 mL serum SST (tiger top tube)

☐ C1q

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

☐ AVISE SLE Monitor

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

☐ EC4d	☐ PC4d
☐ C1q	☐ C3
☐ dsDNA CIA	☐ 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: _____

LM1059 (2/23)

AVISE Specimen Requirements

Order Type	Tube Requirements	Specimen Requirements
AVISE Blood Tests	**One** - 10 mL whole blood EDTA (lavender tube) **One** - 5 mL serum SST (tiger top tube)	• EDTA should be drawn first • Properly dispose of all contaminated materials in accordance with local disposal procedures

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.**

Exagen®

QUESTIONS?

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

AVISE tests are used for clinical purposes, not to be regarded as investigational or for research. Results are not intended to be used as sole means for clinical diagnosis and patient management decisions. The following AVISE tests (AVISE CarP, AVISE CB-CAPs, AVISE CTD, AVISE Lupus, AVISE HCQ, AVISE MTX, AVISE SLE Monitor, AVISE SLE Prognostic) were developed, and performance characteristics were determined by Exagen Inc. as Laboratory Developed Tests (LDTs). The Exagen laboratory is certified under the Clinical Laboratory Amendments of 1988 (CLIA) and accredited by the College of American Pathologists (CAP) as qualified to perform high-complexity clinical laboratory testing, and FDA approval or clearance is not necessary.

 Exagen Inc. Laboratory Directors: Richard Safrin, MD, Raymond H. Summers, MD. CLIA#05D1075048 CAP#7201051 PFI#8369

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

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)

Exagen®
Patient Focused. Discovery Driven.

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

ANSWERING YES TO QUESTIONS A OR B BELOW MAY QUALIFY YOU FOR AVISE® ACCESS†.

A. Did your medical expenses exceed 7.5% of your gross household income or $5,467.50 for the last calendar year? ☐ Yes ☐ No

B. 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	$72,900	$98,600	$124,300	$150,000	$175,700	$185,950	$201,400	$252,800

*Our AVISE support team is here to help. If your household has more than 8 persons, please contact our patient billing specialists at 1-888-452-1522 (select option 2).

☐ Check here if you would like to speak to our patient billing specialists about any questions you may have††.

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 _____

AVISE ACCESS FAQS

1. What are the eligible medical expenses that can be factored into answering "Question A" - Did your medical expenses exceed 7.5% of your gross household income or $5,467.50 for the last calendar year?

Typical expenses include medical, dental and vision insurance premiums, deductibles, co-pays and any expenses associated with those visits. Other common expenses include:

COMMON IRS - QUALIFIED MEDICAL EXPENSES

- Acupuncture
- Alcoholism treatment
- Ambulance services
- Annual physical examination
- Birth control pills (by prescription)
- Chiropractor
- Childbirth/delivery
- Doctor's fees
- Dental treatments (including x-rays, dentures, fillings, oral surgery)
- Dermatologist
- Diagnostic services
- Disabled dependent care
- Drug addiction therapy
- Fertility enhancement
- Gynecologist
- Hearing aids and batteries
- Hospital bills
- Laboratory fees
- Lodging (away from home for outpatient care)
- Nursing home
- Nursing services
- Obstetrician
- Osteopath
- Oxygen
- Pregnancy test kit
- Prescribed medications and drugs (see more information below on common medications)
- Podiatrist
- Psychiatrist
- Psychologist
- Smoking cessation programs
- Surgery
- Therapy or counseling
- Medical transportation expenses
- Transplants
- Vaccines
- Vision care
- Weight loss programs (for a specific disease diagnosed by a physician)
- Wheelchairs
- X-rays

COMMONLY PRESCRIBED MEDICATIONS

- Acid controllers
- Acne medicine
- Aids for indigestion
- Allergy and sinus medicine
- Anti-diarrheal medicine
- Baby rash ointment
- Cold and flu medicine
- Eye drops
- Feminine antifungal or anti-itch products
- Hemorrhoid treatment
- Laxatives or stool softeners
- Lice treatments
- Motion sickness medicines
- Nasal sprays or drops
- Ointments for cuts, burns or rashes
- Pain relievers, such as aspirin or ibuprofen
- Sleep aids
- Stomach remedies

IRS Publication 969

2. If I don't qualify based on questions A or B is there a way to still qualify for AVISE Access?

Yes, please reach out to our patient billing specialists at 888-452-1522 option 2 and let them know you'd like to inquire about alternative qualification options.

3. What type of documentation do I need to provide to qualify?

We only require you to fill out the application, answer yes to option A or B, sign and submit the application. No additional documentation is required.

4. I've submitted an AVISE Access qualification form, why did I receive a large bill from Exagen?

The most common reasons applicants receive a large bill are:

1) Your insurance plan elected to pay you directly for our testing

2) We have an incomplete or unapproved application on file

If you receive a payment from your insurance plan, please call us at 888-452-1522 option 2 to make the payment over the phone or endorse the check payable to Exagen Inc. and mail it to Exagen Inc. PO Box 27561, Albuquerque, NM 87125.

5. Who do I contact if I have a question about an Explanation of Benefits (EOB) or Insurance?

Contact our patient billing specialists at 888-452-1522 option 2 and we will be happy to assist you with any questions you may have. Please remember, an EOB is not a bill from Exagen.

6. You can submit your AVISE Access Qualification form using any ONE of the following methods…

- *Apply electronically at Avisetest.com/access (use the QR code provided on this form) Or,*
- *Fill out page 1 of this form and include with your specimen (ask your provider for assistance) Or,*
- *Mail your completed qualification form to Exagen Inc. PO Box 27561, Albuquerque, NM 87125 Or,*
- *Fax your completed qualification form to Exagen Inc. at 760-479-6486*

Please send your completed form to: Exagen Inc. PO Box 27561, Albuquerque, NM 87125 or fax the form to 760-479-6486. Every effort will be made to process your form expeditiously.

Have questions? Call our AVISE support team at: **1-888-452-1522** (select option 2)

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

Exagen®
Patient Focused. Discovery Driven.