PROTEAN MAPS™ **Test Requisition for Oncology**

Please Fax to 877-764-7628

6555 Sanger Rd Suite 260, Orlando FL 32827
CAP ID#: 8832145 | CLIA ID#: 10D2192649
CDPH ID#: CDS-90005103 | PA LAB ID#: 39259
Medical Director: Anthony Magliocco MD, FCAP

PROTEAN BIODIAGNOSTICS

Customer Service: 1 (754) 242 9682
or support@proteanbiodx.com

Patient Information

Name (Last, First, MI)			
DOB (MM/DD/YYYY)	☐Female (XX) ☐Male (XY) ☐Other_____	Phone (primary)	
Street Address			
City	State	Country	Postal Code
MRN (Medical Record Number)			

Ordering Physician Information

Physician Name	NPI #	Fax	
Office / Practice / Institution		Physician's Email	
Street Address			
City	State	Country	Postal Code
Office Contact Name	Contact Phone	Contact Email	

Insurance Billing Information

Primary Insurance	Policy #	Group #
Primary Policy Holder		DOB
Secondary Insurance	Policy #	Group #
Secondary Policy Holder		DOB

Patient History

Cancer Type:

Other Information:

Specimen Information

Specimen #1	**Location of Tissue:**		
	Case Number:	**Phone #:**	**Fax #:**
Specimen #2	**Location of Tissue:**		
	Case Number:	**Phone #:**	**Fax #:**

Select Specific Tests

Pathology	☐ Case Review ☐ Second Opinion of Diagnosis ☐ HER2 In Situ Hybridization ***Immunohistochemistry:*** ☐ ER ☐ PR ☐ HER2 ☐ PDL1 ☐ Ki67 ☐ P53 ☐ Other_____	
Genomic Profiling	☐ Protean 600+ *(Comprehensive Genomic DNA/RNA NGS Panel)* ☐ Global Methylation	
Rapid Analysis of Gene Mutations	☐ BRAF ☐ EGFR ☐ KRAS ☐ MSI Analysis ☐ Fusion Panel (ALK, RET, ROS1, NTRK 1,2,3, MET exon14 skipping mutation)	☐ Lung HDPCR™ Panel *(Does not include PDL1)*
Liquid Biopsy	☐ CellSearch® *(Circulating Tumor Cell Analysis)* ☐ Liquid Trace™ *(Cell Free DNA & RNA Analysis)**	

☐ **Protean MAPS™ 2024 (pathology review with ancillary studies: IHC, rapid molecular, and NGS)**
Clinically indicated custom panel chosen based on pathologic review and consultation

Submission Checklist	**Required Materials:**	☐ Signed Requisition *(this form)*	☐ Insurance Card *(front & back)*	☐ Pathology Report(s)	**Optional Materials:** ☐ Specimens *(blocks & slides)*

Certificate of Medical Necessity, Consent, Test Authorization, and Physician Signature

My signature is a Certificate of Medical Necessity by the treating physician that this testing has been explained and is authorized for the care of the patient and that consent has been obtained for Protean BioDiagnostics to release results as part of reimbursement, for follow up information to be obtained, and for the data to be de-identified and disclosed for quality assurance and research. Protean BioDiagnostics customer service may be contacted for any discounts if insurance does not fully cover and with any questions. Unless otherwise indicated, it is acknowledged that Protean BioDiagnostics may direct the testing selected based on the requisition and approach listed on the Protean BioDiagnostics website, according to the pathology reports, and status or quantity of the specimen received.

Ordering Physician Signature _____ Printed Name _____ Date (MM/DD/YYYY) _____ / _____ / _____

** For description of molecular tests, visit www.proteanbiodx.com/ordering*

