CASTLE BIOSCIENCES

DecisionDx SCC

Customer service: **866-788-9007**
Email: **clinicalservices@castlebiosciences.com**

Fax toll free: **866-329-2224**
Alternate fax: **602-222-5200**

I. Ordering entity information

Provider name*	Specialty	NPI	Institution / Practice name*
Address*		City / state / zip*	
Office contact name*	Phone*	Fax*	Email

II. Patient information

Name (last, first, MI)*	DOB*	Gender	SSN / MR#
Address*	City / state / zip*		
Phone*	Email		

III. Billing information

Submitting diagnosis / ICD-10 code*

Please select code from dropdown list

Payment method ☐ Private insurance ☐ Patient self-pay ☐ Medicare ***Section IV required**
☐ Medicaid ☐ Client bill *(contracted entities only)*

Insurance name	Policy #*	Insurance phone	Secondary insurance? ☐ Yes ☐ No *(If yes, attach copy of card)*

IV. Facility information*

At time of tissue collection, was this patient: ☐ Non-hospital ☐ Hospital outpatient ☐ Hospital inpatient If hospital inpatient, discharge date: _____

If specimen is stored **for more than 30 days** from the date of collection, please provide the date specimen is pulled from archive: _____

V. Clinical information (Required - this test is validated for patients with one or more high-risk features. Please check all that apply from the table below)*

HISTORY AND PHYSICAL EXAM

- ☐ Tumor size ≥2cm anywhere on the body
- ☐ Tumor location on the head, neck, hands, genitals, feet or pretibial surface *(areas H or M)*
- ☐ Immunosuppression
- ☐ Rapidly growing tumor
- ☐ Tumor with poorly defined borders
- ☐ Tumor at site of prior radiation therapy or chronic inflammation
- ☐ Neurologic symptoms in region of tumor

SURGICAL AND PATHOLOGY FINDINGS

- ☐ Perineural involvement *(Large (≥0.1 mm) or named nerve involvement; Small (<0.1 mm) in caliber)*
- ☐ Poorly differentiated tumor histology
- ☐ Depth *(Invasive beyond subcutaneous fat or Invasion beyond 2mm or Clark Level IV)*
- ☐ Aggressive histologic subtype^A
- ☐ Lymphovascular invasion
- ☐ Desmoplastic SCC

DecisionDx-SCC has not been evaluated for testing in tissue from locally recurrent tumors

^A^Acantholytic (adenoid), adenosquamous (showing mucin production), or carcinosarcomatous (metaplastic) subtypes (others will be considered on a case-by-case basis)

VI. Required signature

This signature confirms this test to be medically necessary for this patient. This clinician provides consultation and/or treatment for squamous cell carcinoma and will use the results in the management of the patient.

Signature of treating clinician*	Printed name*	Date

VII. Treating clinician

Provider name *(if different than section I)*	Phone	Fax	Institution / Practice name
Address (☐ same as requestor)	City / state / zip		

VIII. Laboratory contact information

Facility where tissue is maintained	☐ MOHS debulk in formalin	Collection date
Phone	Fax	

Please fax this requisition along with a copy of the pathology report from the primary biopsy and Mohs report (if available)

For internal use only		
Received	Processed by	Materials received
PR / Initials	DTL	Note

* Required item

SECTION I. Complete with information of the ordering entity.

SECTION II. Complete with patient information.

SECTION III. Provide the ICD-10 code and patient's diagnosis. Select method of payment. Please complete with billing information including a copy of the front and back of the insurance card (if applicable). If the person completing this requisition is not in possession of the information necessary for completion of the billing information section, please provide the name/department and contact information of the appropriate party from whom this information can be obtained.

Name: _____ Department: _____
Phone: _____ Fax: _____

**If a copy of the front and back of the insurance card is provided, no further information is needed in this section of the requisition. A billing face sheet is also sufficient in lieu of copy of card.*

SECTION IV. Applicable only for patients with Traditional Medicare as their primary insurance.

SECTION V. This test is validated for patients with squamous cell carcinoma tumors which have at least one high risk feature. This/these feature(s) can be either clinical in nature, or pathology derived, or both. Please select all that apply from the list provided in section V titled "Clinical information". Note: DecisionDx-SCC has not been evaluated for testing in tissue from locally recurrent tumors.

SECTION VI. The ordering clinician must sign this section. ***For purposes of ordering this test, the "ordering clinician" section can be signed only by a physician, advanced practice registered nurse (APRN), or representative Physician Assistant (PA)***

SECTION VII. Complete with information for the treating clinician and/or clinicians. If the mailing address is the same as for the ordering clinician, check the box "same as requestor".

SECTION VIII. Complete this section with the name of the facility where the tissue from which the slides for testing will be requested. Provide the name and phone number of an individual to whom a tissue request should be made.

Contact customer service: **866-788-9007**
Fax the following documents toll free: **866-329-2224**
or email **reqs@castlebiosciences.com** (Alternate fax: **602-222-5200**).

Required to submit a complete order

- Completed requisition
- Pathology report(s)
- Mohs report (if available)

If you are interested in online ordering, please contact us at
clinicalservices@castlebiosciences.com

CASTLE BIOSCIENCES

3737 N 7th Street, Suite 160
Phoenix, AZ 85014
castlebiosciences.com

100 S. Commons, Suite 245
Pittsburgh, PA 15212