AlfredHealth (A.P.A.)
Alfred Pathology Service

# MOLECULAR HAEMATOLOGY TEST REQUEST FORM

RCPA NATA
The Royal College of Pathologists of Australasia
LABORATORY NUMBER 2349

| PATIENT INFORMATION | | REQUESTING CLINICIAN / PATHOLOGIST | |
|---|---|---|---|
| Surname: | Sex: M / F | Name: | |
| First Name: | DOB: | Hospital/Lab: | |
| Address: | | Provider No: | |
| | | Tel: | Fax: |
| Medicare Number: | | Referrer Signature:_____ | |
| Private Health Fund: Health Fund Number: | | Date:_____ | |
| | | *Note that you are also accepting full responsibility for this pathology request.* | |

## CLINICAL AND SAMPLE DETAILS

**Clinical Notes / Reason for Test:** *(Attach a copy of relevant Pathology Reports)*

**Sample Details**
Collection Date/Time: _____
❑ Bone Marrow ❑ Blood
❑ Other (specify) _____
**Container Type (circle)**
EDTA / DNA / RNA / Trizol

## SELECT TEST(S)

### Diagnosis/Relapse Screening Tests

- ❑ **FLT3-ITD, FLT3-TKD, and NPM1**
- ❑ **JAK2 V617F**
- ❑ **FIP1L1::PDGFRA**

**Myeloid NGS Panel** - 52 genes – list of targets on page 2

- ❑ **Suspected Myeloid Malignancy** (MBS item 73447)
- ❑ **PMF, Transplant eligible** (MBS item 73399)
- ❑ **ET/PV** (MBS item 73398)

### Quantitative MRD Monitoring Tests

**Please provide details of the specific mutation detected at diagnosis when sending the first sample to the lab.*

Specify Mutation Type*

- ❑ **NPM1** _____
- ❑ **IDH1** _____
- ❑ **IDH2** _____
- ❑ **KMT2A::X** _____
- ❑ **FLT3-ITD**

## SELECT PAYMENT OPTION

❑ **Bill Medicare** *(Patient must sign. Non-rebatable components will be billed to the pathology provider unless otherwise specified )*

If a test is being requested through Medicare the patient's hospital status at the time of the service or when the specimen was collected is required:

- ❑ Private Patient in a private hospital or approved day hospital
- ❑ Private Patient in a recognised hospital
- ❑ Public Patient in a recognised hospital
- ❑ Outpatient in a recognised hospital

Patient's Signature:_____ Date:_____

**Medicare Assignment Form (Section 20A of the Health Insurance Act 1973)**
*I assign my right to benefits to the approved pathology practitioner who will render the requested pathology service(s).*

❑ **Bill Hospital/Pathology Provider** Direct

❑ **Bill Patient** Direct *(Must sign declaration overleaf)* ❑ **Other:** _____

**PROVIDE THE FOLLOWING:**

- This completed form
- Appropriate sample (Please see page 2 of this form)
- Copy of the Pathology Test Report if relevant

**SEND TO: HMP@Alfred.org.au**
Alfred Pathology – Central Specimen Reception
Alfred Hospital, Commercial Road, Melbourne, VIC 3004
Fax: (03) 9076 3424 Tel: (03) 9076 2383

*Your doctor recommended that you use Alfred Pathology. You are free to choose your own pathology provider.*
*However, if your doctor has specified a particular pathologist on clinical grounds, a Medicare rebate will only be payable if that pathologist performs the service.*
*You should discuss this with your doctor.*

**Privacy Note:** The information provided will be used to assess any Medicare benefit payable for the services rendered and to facilitate the proper administration of government health programs, and may be used to update enrolment records. Its collection is authorised by provision of the *Health Insurance Act 1973*. The information may be disclosed to the Department of Health and Ageing or to a person in the medical practice associated with this claim, or as authorised/required by law.

| Test | Genes/targets covered | Price* |
|---|---|---|
| Myeloid NGS panel (52 genes)<br><br>All exons in the genes listed are covered unless otherwise specified | ASXL1, BCOR, BCORL1, CALR (exon 9), CBL (exon 2-3, 6-10, 13, 15), CEBPA, CISH, CSF3R (exon 14, 17), DDX41, DNMT3A, EPOR, ETV6, EZH2, FLT3 (exon 14-17, 20, 21), FOXO3, GATA2, GNAS, IDH1 (exon 4, 7-9), IDH2 (exon 4, 7), JAK1 (exon 14), JAK2 (exon 1-14, 16-25), JAK3, KIT (exon 8, 11, 13-14, 17-18), KLF3, KRAS (exon 2-4), MPL, NF1, NFE2, NPM1 (exon 12), NRAS (exon 2-3), PHF6, PTPN11 (exon 3, 8, 11-13), PPM1D, RAD21, RUNX1, SETBP1 (partial exon 4), SF3B1 (12, 14-15), SH2B3, SMC1A, SMC3, SOCS1, SOCS2, SOCS3, SRSF2 (exon 1, 2), STAG1, STAG2, STAT5B, TET2, TP53, U2AF1 (exon 2, 6) WT1 (exon 6-8), ZRSR2. | MBS73447 $829.20<br>MBS73399 $601.30<br>MBS73398 $357.00 |
| NPM1 MRD | RT-qPCR - c.860_863dup (Type A), RT-ddPCR - c.863_864insNNNN | $196.35 |
| IDH1 ddPCR | c.394C>T p.R132C, c.394C>G p.R132G c.394C>A p.R132S<br>c.395G>A p.R132H, c.395G>T p.R132L | $196.35 |
| IDH2 ddPCR | c.419G>A p.R140Q, c.515G>A p.R172K | $196.35 |
| KMT2A::X RT-ddPCR | t(9;11)(p23;q23)/KMT2A::MLLT3, t(6;11)(q27;q23)/KMT2A::AFDN, t(10;11)(p12;q23)/KMT2A::MLLT10<br>t(11;19)(q23;p13.1)/KMT2A::ELL, t(11;19)(q23;p13.3)/KMT2A::MLLT1, t(4;11)(q21;q23)/KMT2A::AFF1 | $196.35 |
| JAK2 ddPCR | c.1849G>T p.V617F | $63.35 |
| FLT3-ITD/TKD and NPM1 Fragment Analysis | ITDs in exons 14 and 15 of FLT3, TKD mutations at FLT3 codons encoding D835/I836, and insertions in the last exon of NPM1. | $196.35 |
| FLT3-ITD MRD NGS | ITDs in exons 14 and 15 of FLT3 | $196.35 |
| FIP1L1::PDGFRA qPCR | All common FIP1L1::PDGFRA fusion variants | $196.35 |

*Claimable through Medicare if eligible: Medicare Item Numbers 73447, 73399, 73398, 73314, 73325, 73326

## SAMPLE REQUIREMENTS:

- **DNA testing: Myeloid NGS, FLT3-ITD/TKD and NPM1 FA, JAK2 and IDH1/2 ddPCR, FLT3-ITD MRD NGS.**
  - 9ml peripheral blood (EDTA) OR
  - 2-4ml of bone marrow (EDTA) OR
  - DNA (minimum 10ul at 50ng/µl)

- **RNA testing: NPM1 MRD, KMT2A-X MRD and FIP1L1-PDGFRA**
  Blood and BM must be received within 48 hours of collection.
  - 9ml peripheral blood (EDTA) OR
  - 2-4ml of bone marrow (EDTA) OR
  - WC pellet resuspended in Trizol
  - RNA (minimum 10ul at 200ng/µl)

**BILL PATIENT DIRECT DECLARATION: Billing of Non-Medicare Rebatable Tests**

The pathology request that you have been given by your medical practitioner includes tests that could be either partially or not covered by Medicare.

If required, the full cost of testing must be covered by the patient or, in the case of children, their family. Alfred Pathology requires your consent to proceed with this testing with the full understanding that you will accept responsibility for payment.

Patient Name: _____

Test Name(s) : _____

The cost of the test requested by your doctor is estimated at A$ _____

I hereby agree to accept responsibility for full payment or part payment of non-Medicare rebatable tests performed by Alfred Pathology.

Patient/ Parent Signature _____

Date____/___/____

For further information, please contact Alfred Pathology on 9076 3118.