MagArray

REVEAL

LUNG NODULE CHARACTERIZATION

MagArray, Inc.
521 Cottonwood Dr., Suite 121
Milpitas, CA 95035
clientservices@magarray.com
Phone: (408) 753-6429
Fax: (844) 825-7635
Hours: Mon - Fri 9:30 AM – 8:00 PM EST

Provider and Order Information

Healthcare Organization: _____

Clinician Name: _____

NPI#: | | | | | | | | | | |

Street Address: _____

City, State, Zip: _____

Phone Number: _____

Secure Fax Number*: _____

***Test results and updates will be sent to this fax number**

Email Address: _____

ICD-10 Code(s)

☐R91.1 Solitary Pulmonary Nodule
☐R91.8 Abnormal findings of Lung (Multiple Pulmonary Nodules)
☐Other_____

The above codes are listed as a convenience. Ordering clinicians should report the diagnosis code(s) that best describes the reason for ordering the test, regardless of whether the code is listed above or not.

*Plasma samples from patients who have received mouse-antibody based therapies may interfere with the **REVEAL** test, which can cause inaccurate results.*

Certification

I am a licensed treating clinician authorized to order **REVEAL**. This test is medically necessary, and the patient is eligible for **REVEAL**. I will maintain the privacy of test results and related **REVEAL** information as required by HIPAA.

Ordering Clinician Signature **Date of Order**

Patient Information

First: _____ Last: _____

DOB: _____ Phone Number: _____

Address: _____

City, State, Zip: _____ SSN: _____

Preferred Contact Method ☐Phone ☐Text ☐Email: _____

Required Clinical Information

Sex: ☐Female ☐Male

Nodule Size: _____(4 mm to 30 mm)

Current Smoker: ☐Yes* ☐No

***REVEAL is only available for current smokers**

Patient Authorization and Financial Responsibilities

For patients covered by Medicare please use the Advance Beneficiary Notice of Noncoverage (ABN) on the reverse side of this form.
For all other patients please sign the statement below:

I understand I am responsible for the cost of the **REVEAL** test. An invoice for the **REVEAL** test will be sent to me once a successful test result is returned to my clinician.

Patient Signature:_____ Date:_____

MagArray is pleased to offer a financial assistance program to make the cost of the test affordable to any patient who may benefit from **REVEAL**. Please contact MagArray Client Services at (408) 753-6429 for more details.

Ordering Information and Next Steps

For mobile phlebotomist: Please fax this form to MagArray at (844) 825-7635. MagArray will order mobile phlebotomy for your patient. The phlebotomist will call your patient promptly to schedule their blood draw and then ship the drawn specimen to MagArray directly.

For in-office blood draw: Please follow the instructions included with this form to draw and ship patient specimens to MagArray. If a specimen collection and shipping kit is needed please contact MagArray at (408) 753-6429.

Specimen Collection Information

I, the phlebotomist named below, verify that the enclosed specimen was collected and processed according to the protocol provided by MagArray, Inc. I verify that this specimen is the specimen taken from the patient named on this form.

Collection Date:_____ Collected By:_____

Phone/Email:_____

For Phlebotomy Use Only: Affix Sample Label

MagArray Lab Use Only:
Date/Time Received:_____
Received By:_____

For MagArray Use Only: Affix Accession Label

MagArray, Inc.
CLIA ID#: 05D2135449
CR0019-ART-7.0P

MagArray
Questions? Call (408) 753-6429

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PATIENT NAME: **IDENTIFICATION NUMBER:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: ***If Medicare doesn't pay for the laboratory test below, you may have to pay.***

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the laboratory test below.

Laboratory Test	Reason Medicare May Not Pay:	Estimated Cost
REVEAL Lung Nodule Characterization	**Medicare does not pay for this test for your condition.**	**$3,500**

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the laboratory test listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the laboratory test listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the laboratory test listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the laboratory test listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	Date:

CMS DOES NOT DISCRIMINATE IN ITS PROGRAMS AND ACTIVITIES. TO REQUEST THIS PUBLICATION IN AN ALTERNATIVE FORMAT, PLEASE CALL: 1-800-MEDICARE OR EMAIL: ALTFORMATREQUEST@CMS.HHS.GOV.

REVEAL Sample Collection, Handling Procedures, and Shipping Instructions

Thank you for reading carefully

1. Freeze the ice pack included in the shipping kit for at least 24 hours.
2. Follow standard blood-borne pathogen safety precautions.
3. Using water resistant ink, label the lavender top tube, secondary collection tube and Test Requisition Form with the patient's full name, and date of birth using the included barcoded labels. The Patient ID, time of collection, and the Physician's/Clinic's name are also recommended. Ensure each of the completed labels is firmly affixed. **IMPORTANT:** A tube without at least 3 unique identifiers (e.g., patient's full name, date of birth and unique barcode) may be rejected.
4. Collect ≥3 mL of blood in a K_2EDTA lavender top tube. Samples collected in other tubes may be rejected.
5. GENTLY invert the lavender top tube ten (10) times immediately after collection to ensure the anticoagulant is adequately mixed with the blood sample.
6. The lavender top tube must be centrifuged right after the blood is collected so that the plasma fraction can be transferred into the secondary transport tube. Do not store the whole blood tube refrigerated or frozen. Once the plasma is placed into the secondary transport tube, it can be stored refrigerated until shipped that day, or frozen for shipment at a later date.
7. Centrifuge the lavender top tube at 1200 X g for 10 minutes.
8. Using the provided pipette, transfer at least 1 mL of plasma into the provided secondary tube. A secondary tube without sufficient sample volume may be rejected.
9. The plasma sample secondary tube may now be refrigerated *for a maximum of two days* or frozen until ready to ship. **IMPORTANT:** Once frozen, avoid thawing the sample.
   NOTE: Use a dedicated freezer for blood products/bodily fluids if freezing the sample. If one is not available, consider drawing the patient's sample no later than Friday -- *early enough in the day* -- to enable shipping the sample to MagArray that same day. Do not ship samples on a Saturday.
10. Place the refrigerated or frozen sample in the 2-bay absorbent pouch. Place the 2-bay absorbent pouch into the biohazard specimen bag and seal.
11. Include the patient's Test Requisition Form with their sample. Fold the Test Requisition Form into quarters and place in the exterior pocket of the biohazard bag (not in the pocket with the sample tube.)
12. Place the biohazard bag, with the sample, and Test Requisition Form included, in the metalized bubble pouch and seal. Place the metalized bubble pouch in the Styrofoam container.
13. Place the frozen ice pack in the Styrofoam container on top of the metalized bubble pouch.
14. Replace the top of the Styrofoam container and place the Styrofoam container into the white cardboard shipping box if it was removed. Close the white cardboard shipping box with the Styrofoam container inside.
    NOTE: Only the smaller white shipping box (8" x 6.5" x 4.5") needs to be used to ship the sample to MagArray. The larger box and materials used to send the shipping kits to you may be discarded.
15. **Ship promptly**. Ship samples via FedEx or UPS Monday through Friday by **Priority Overnight Air Delivery** to:
    MagArray, Inc • 521 Cottonwood Dr., Suite 121 • Milpitas, CA 95035 • (408)753-6429

For help scheduling a pickup, please contact MagArray Customer Service at (408) 753-6429.

Samples are accepted Tuesday through Saturday only.
Thank you for shipping the sample Priority Overnight Air Delivery.

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