UNITY BY BILLIONTOONE

REQUISITION FORM

1 SELECT TEST PANEL

Samples without a test panel selected will not be processed.

UNITY Carrier Screen™

☐ ***CFTR • SMN1 • HBB • HBA***

☐ add Fragile X

A separate cfDNA fetal risk assay will be run for carrier positive singleton pregnancies. Check here to opt out: ☐

UNITY Aneuploidy™ and 22q11.2 Microdeletion

singleton pregnancy

☐ ***chromosomes: 13 • 18 • 21 • X • Y • 22q11.2***

☐ order for twin pregnancy NIPT analysis†

13, 18, 21, and 22q11.2 only. Zygosity included.

OR

UNITY Aneuploidy™

singleton pregnancy

☐ ***chromosomes: 13 • 18 • 21 • X • Y***

☐ order for twin pregnancy NIPT analysis†

13, 18, and 21 only. Zygosity included.

☐ add fetal RhD for RhD-negative mothers†

☐ opt out fetal sex†

† Includes Aneuploidy NIPT

add **Fetal Antigen(s)** for known alloimmunized patients only†

☐ C antigen (Big C) ☐ D antigen
☐ c antigen (little c) ☐ E antigen
☐ Fya (Duffy) antigen ☐ K (Kell) antigen

* MUST INCLUDE TREATMENT NOTES TO ORDER *

2 SAMPLE COLLECTION DATE & BARCODE

MM-DD-YYYY

PLACE PROVIDED BARCODE HERE

3 CLINICAL INDICATION

Required to select at least one for each test panel. The following codes are not exhaustive.*

UNITY Carrier Screen

If the patient with singleton pregnancy is found to be a carrier for tested disorders, fetal risk assessment will be performed and O28.5 ICD-10 code will be applied, unless opted out.

☐ Family history of carrier genetic disease**	Z84.81	Z84.89	
☐ Testing for genetic disease carrier status	Z31.430	Z31.440	
☐ Supervision of other normal pregnancy	Z34.81	Z34.82	Z34.83
☐ Family history of intellectual disabilities	Z81.0		
☐ Other: _____			

UNITY Aneuploidy *Code determined by trimester of pregnancy.*

☐ Supervision of elderly primigravida	O09.511	O09.512	O09.513
☐ Supervision of elderly multigravida	O09.521	O09.522	O09.523
☐ Supervision of other high risk pregnancies	O09.891	O09.892	O09.893
☐ Supervision other normal pregnancy	Z34.81	Z34.82	Z34.83
☐ Abnormal ultrasound findings	O28.3		
☐ Abnormal chromosomal & genetic findings	O28.5		
☐ Other: _____			

UNITY Fetal RhD NIPT *Code determined by trimester of pregnancy.*

☐ Maternal care for anti-D [Rh] antibodies	O36.0110	O36.0120	O36.0130
☐ Encounter for Rh incompatibility status	Z31.82		
☐ Other: _____			

*ICD-10 code selected under one test panel might be used in other test panels' billing.
**Requires Additional Code

Ordering Healthcare Provider(s) *

PROVIDER AUTHORIZATION

By submission of this requisition and accompanying sample, I hereby authorize and direct BillionToOne to (1) utilize the above information to process the indicated test for this patient and (2) release the results and patient information to the patient's third-party payer, as needed. I certify (1) all information provided herein is true and accurate, (2) I am authorized by law to request the test, (3) the test is reasonable and medically necessary for the treatment and management of this patient, (4) the patient has been counseled on the potential results, benefits and limitations of the test, and (5) I have obtained informed consent to the extent required under applicable law. I agree to provide the necessary information and medical records to BillionToOne needed to submit and process claims to payers.

Provider Signature * _____ MM-DD-YYYY Date of Authorization

4 PATIENT INFORMATION

First Name * _____ MI _____ Last Name * _____

Sex assigned at birth * _____ Maternal Weight _____ lbs Date of Birth * MM-DD-YYYY Estimated Due Date * MM-DD-YYYY ☐ not pregnant

By providing the information below, I agree I or my provider may be contacted for test status, billing/collection, marketing, quality assurance or research purposes.

Cell Phone * _____ Email _____

Street Address _____ Apt / Unit / Suite _____

City _____ State _____ Zip Code _____

Pregnancy Details *Select if applicable*

☐ twins ☐ triplets or more ☐ vanishing twin
☐ egg donor/gestational carrier age of egg donor

Abnormal Ultrasound Findings _____

Ethnicity or Race * ICD-10 code Z15.89 will be applied for high risk ethnicities.

☐ Asian ☐ African/African American ☐ Ashkenazi Jewish ☐ Middle Eastern
☐ French Canadian/Cajun ☐ Hispanic ☐ White ☐ other ☐ unknown

Reported Carrier/Family History

Maternal:
☐ alpha thal ☐ sickle cell / HBB ☐ SMA ☐ CF specify variant ☐ fragile X

Paternal:
☐ alpha thal ☐ sickle cell / HBB ☐ SMA ☐ CF specify variant ☐ fragile X

Family History _____

PATIENT ACKNOWLEDGEMENT I acknowledge I have read and agreed to the Patient Acknowledgement for testing on the back page.

Patient Signature * _____ MM-DD-YYYY Date of Acknowledgement

5 CLINIC INFORMATION

Clinic Name * _____

Clinic Phone _____ Clinic Fax _____ Clinic Account Number _____

Additional Notes _____

6 BILLING INFORMATION

☐ **Bill to Insurance** ☐ **Bill to Patient** ☐ **Bill to Client**

☐ Ordering provider or facility is out-of-network with the patient's insurance plan

Attach copy of insurance card

Insurance Company Name _____

Member ID _____ Group ID _____

UNITY BY BILLIONTOONE

TEST PANEL	TEST DETAILS	SAMPLE REQUIREMENT
UNITY Complete®	**UNITY Carrier Screen + UNITY Aneuploidy** See conditions below	**3** x 10 mL Streck cell-free DNA BCT® blood tube **Fill to the top (≥ 8mL)**
UNITY Carrier Screen *Fetal risk assessment will be provided for positive carrier test results unless opted out*	**recessive conditions screened** • **cystic fibrosis** *CFTR* • **spinal muscular atrophy (SMA)** *SMN1* • **hemoglobinopathies (sickle cell disease, alpha / beta thalassemia)** *HBB, HBA* • **optional fragile X** *FMR1* (Fetal sex via cfDNA will be provided for all positive carriers)	**1** x 10 mL Streck cell-free DNA BCT® blood tube **Fill to the top (≥ 8mL)**
UNITY Aneuploidy	**chromosomal conditions screened** • **trisomy 21, 18, 13** • **sex chromosome aneuploidy (monosomy X, XXY, XXX, XYY)** • **zygosity determination included for twin pregnancies** • **optional fetal sex reporting** • **optional fetal RhD reporting for RhD-negative pregnant patients** • **optional fetal antigen reporting for alloimmunized patients** • **optional 22q11.2 microdeletion**	**2** x 10 mL Streck cell-free DNA BCT® blood tube **Fill to the top (≥ 8mL)**

Sex chromosome aneuploidies and fetal risk assessment for recessive conditions can only be performed for singleton pregnancies > 9 weeks of gestation. Fetal risk assessment for recessive conditions cannot be performed for egg donors or gestational carriers.

ICD-10 DIAGNOSIS CODES

Codes below are not exhaustive, provide additional codes as necessary.

UNITY Carrier Screen

Female for testing for genetic disease carrier status for procreative management	**Z31.430**
Male for testing for genetic disease carrier status for procreative management	**Z31.440**
Supervision of normal first pregnancy, unspecified trimester	**Z34.00**
Supervision of normal first pregnancy, first trimester	**Z34.01**
Supervision of normal first pregnancy, second trimester	**Z34.02**
Supervision of other normal pregnancy, unspecified trimester	**Z34.80**
Supervision of other normal pregnancy, first trimester	**Z34.81**
Supervision of other normal pregnancy, second trimester	**Z34.82**
Supervision of normal pregnancy, unspecified, first trimester	**Z34.91**
Family history of intellectual disabilities	**Z81.0**
Family history of carrier genetic disease	**Z84.81**
Family history of other specified conditions	**Z84.89**

UNITY Aneuploidy Screen

Supervision of elderly primigravida, first trimester	**O09.511**
Supervision of elderly primigravida, second trimester	**O09.512**
Supervision of elderly multigravida, first trimester	**O09.521**
Supervision of elderly multigravida, second trimester	**O09.522**
Supervision of other high risk pregnancies, first trimester	**O09.891**
Supervision of other high risk pregnancies, second trimester	**O09.892**
Abnormal ultrasonic finding on antenatal screening of mother	**O28.3**
Abnormal chromosomal and genetic finding on antenatal screening of mother	**O28.5**
Maternal care for (suspected) chromosomal abnormality in fetus	**O35.1XX0**
Maternal care for (suspected) chromosomal abnormality in fetus 1	**O35.1XX1**
Encounter for Rh incompatibility status	**Z31.82**
Encounter for antenatal screening for chromosomal anomalies	**Z36.0**
Family history of chromosomal abnormalities	**Z82.79**

PATIENT ACKNOWLEDGEMENT

Read and sign the front page.

I have been informed of and understand the details of the tests ordered herein for me by my healthcare provider, including the risks, benefits and alternatives, and consented to testing. I understand (1) the test results may inform me of a medical condition that may require follow-up and (2) a negative result does not rule out the possibility of such medical condition in the fetus, myself or my partner. I hereby authorize (1) the release to BillionToOne of any medical and insurance information necessary to process claims and recover reimbursement for services provided by BillionToOne and (2) BillionToOne to pursue all necessary appeals of any denials of payment in relation to services provided by BillionToOne. I understand that the test may not be (1) covered by my insurer/health plan, or (2) deemed medically necessary and I am responsible for any costs not paid by my plan directly to BillionToOne, including any copayments, deductibles or amounts deemed 'patient responsibility'. I acknowledge that I may be responsible for non-covered services. BillionToOne may (1) contact my healthcare provider to obtain more information regarding clinical correlation and confirmatory testing and (2) contact my provider or me for test status, billing/collection, quality assurance or research purposes.

BEFORE YOU SHIP, please ensure that:

- ☑ **Test panel** and **ICD10 codes** are selected
- ☑ **Required fields** on this form are completed
- ☑ **Insurance card copies** are included (front and back)
- ☑ **Provided barcode** is affixed to tubes and this form
- ☑ Requisition is **signed**

Call **1-800-463-3339 (1-800-GO FEDEX)** to schedule a pickup