natera | Prospera™ Transplant assessment

ARUP USE ONLY
Master Label Area

THIS IS NOT A TEST REQUEST FORM. YELLOW FIELDS ARE REQUIRED.
FRONT & BACK COPIES OF INSURANCE CARD ARE ALSO REQUIRED.
Please submit these with the electronic packing list.

PATIENT INFORMATION

Patient Last Name | Patient First Name | Patient Weight (lbs.) | Date of Birth (MM/DD/YY) | ☐ F ☐ M Biological Sex

Patient Email | Cell Phone

Address | City | State | Zip

ORDERING CLINICIAN

Clinic or Organization

Ordering Clinician Name | NPI Number | Telephone

Fax | Address | Additional Report Recipient | Fax

City | State | Zip | Ordering Clinician / Authorized Signature

STATEMENT OF MEDICAL NECESSITY: I confirm the testing ordered herein is medically necessary and this patient has been informed of the details of the genetic test(s) ordered, including the risks, benefits, and alternatives, and has consented to testing as may be required by law, including NY CVR §79-l, as applicable.

PROSPERA™ TEST ORDERING

PROSPERA: (Required: Select one below):

☐ Single Order ☐ Recurring Order

Sample Requirements: Two 10mL Tiger-top Streck Cell-Free DNA BCT® blood tubes 

Prospera is not indicated in patients who are: pregnant, less than two weeks post-transplant, recipients of an allograft from an identical twin, recipients of an allogeneic stem cell transplant, or recipients of a non-kidney organ transplant.

Date of Sample Collection (MM/DD/YY)

ICD-10 CODE (Required: Select one of the choices below):

☐ T86.10 Unspecified complication of kidney transplant
☐ Z94.0 Kidney transplant status
☐ Z48.22 Encounter for aftercare following kidney transplant
☐ Other _____

PATIENT HISTORY

Date of Transplant (MM/DD/YY) | ☐ Living ☐ Deceased Donor Type | ☐ Yes ☐ No Donor Biologically Related | If Related, Define Relationship

PAYMENT INFORMATION

Primary Insurance | Subscriber ID | Secondary Insurance | Subscriber ID

PATIENT ACKNOWLEDGMENT

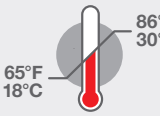
I have been informed of and understand the details of the tests ordered herein for me by my health care provider, including the risks, benefits and alternatives, and I have consented to testing. I understand that negative results do not rule out the possibility of an issue with the health of my kidney. I authorize Natera or other provider to share the information on this form and my test results with my health insurer/health plan/Medicare ("plan") on my behalf, with all benefits of my plan made payable directly to Natera or other provider/s. I assign to Natera the right to appeal on my behalf negative coverage decisions made by my plan and to assert all rights and claims reserved to me as the beneficiary thereof. The information obtained from my tests may be used in scientific publications or presentations but my specific identity will not be revealed. Natera may reach out to my healthcare provider to obtain more information regarding clinical correlation and confirmatory testing. My leftover samples may be de-identified and used for research and development. I and my heirs will not receive payments, benefits, or rights to any resulting products or discoveries. If I do not want my samples used, I may send a written request to Natera Sample Retention Department at the address written below within 60 days after test results have been issued and my samples will be destroyed.

By my signature I acknowledge I have read this Patient Acknowledgment for testing. New York residents must check this box ☐ and sign below to permit Natera to use their samples for research and development; otherwise, their samples will be discarded within 60 days of testing. Natera may use the information included herein to contact me on my cell phone, home phone, email, or via text messaging for treatment options, billing/collection matters and health-related products, services or studies unless I opt out by checking this box. ☐

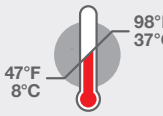
Patient Signature | Date

Prospera™
Transplant assessment

Sample Collection Instructions



DO NOT store kits in an area where the temperature range is outside 65°F–86°F (18°C–30°C).



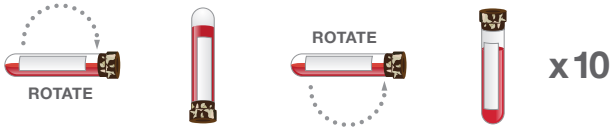
DO NOT expose blood to temperatures outside the range of 47°F–98°F (8°C–37°C).

1. Collect the patient's blood

10 mL of blood in each of two Streck cell-free DNA tubes

- Fill both tubes completely. If insufficient volume is obtained, please draw an additional tube.
- Allow 60–90 seconds for each tube to fill.
- Use a 21 gauge straight needle. **DO NOT** use a butterfly needle.
- Vein collapse may require a second venipuncture with a fresh tube.

2. Gently mix the sample



- Gently invert each tube at least 10 times immediately after draw in order to thoroughly mix blood with reagents.
- **DO NOT** shake vigorously.
- **DO NOT** seal tubes with paraffin film.

3. Pre-pack the sample

A
Affix LIS labels (with two unique identifiers).

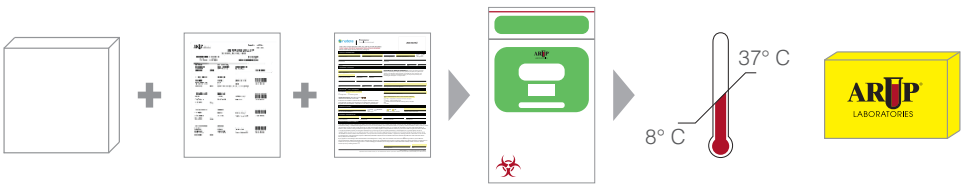
B
Place tubes inside provided biohazard bag.

C
Place the bag inside gel pack to cushion.

D
Place the gel pack in the metallic envelope.

E
Place in kit.

4. Ship the sample



Kit

Packing List

Patient history form

Biohazard bag

Do not freeze or refrigerate.

Ship to ARUP.

This test was developed by Natera, Inc., a laboratory certified under the Clinical Laboratory Improvement Amendments (CLIA). This test has not been cleared or approved by the US Food and Drug Administration (FDA). Although FDA does not currently clear or approve laboratory-developed tests in the US, certification of the laboratory is required under CLIA to ensure the quality and validity of the tests.