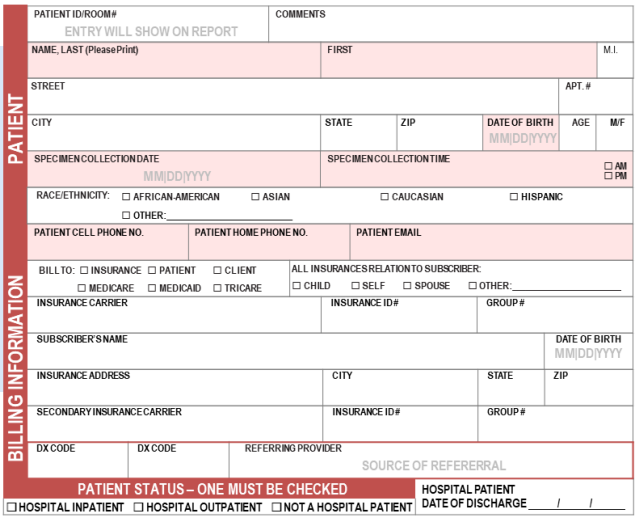
The 4Kscore® Test

Requisition Completion Guide

1 Patient & Billing Information

- ✓ Please complete Patient and Billing Information sections.
- ✓ If sending a Face Sheet / Demographic Sheet for the patient with the requisition, only the following information is required:
  - → Patient Name
  - → Date of Birth
  - → Date and Time of Collection
- ✓ An appropriate Diagnosis Code is required.



PATIENT

PATIENT ID/ROOM# ENTRY WILL SHOW ON REPORT | COMMENTS

NAME, LAST (Please Print) | FIRST | M.I.

STREET | APT. #

CITY | STATE | ZIP | DATE OF BIRTH MM|DD|YYYY | AGE | M/F

SPECIMEN COLLECTION DATE MM|DD|YYYY | SPECIMEN COLLECTION TIME ☐ AM ☐ PM

RACE/ETHNICITY: ☐ AFRICAN-AMERICAN ☐ ASIAN ☐ CAUCASIAN ☐ HISPANIC ☐ OTHER:_____

PATIENT CELL PHONE NO. | PATIENT HOME PHONE NO. | PATIENT EMAIL

BILLING INFORMATION

BILL TO: ☐ INSURANCE ☐ PATIENT ☐ CLIENT ☐ MEDICARE ☐ MEDICAID ☐ TRICARE

ALL INSURANCES RELATION TO SUBSCRIBER: ☐ CHILD ☐ SELF ☐ SPOUSE ☐ OTHER:_____

INSURANCE CARRIER | INSURANCE ID# | GROUP #

SUBSCRIBER'S NAME | DATE OF BIRTH MM|DD|YYYY

INSURANCE ADDRESS | CITY | STATE | ZIP

SECONDARY INSURANCE CARRIER | INSURANCE ID# | GROUP #

DX CODE | DX CODE | REFERRING PROVIDER SOURCE OF REFERERRAL

PATIENT STATUS – ONE MUST BE CHECKED

☐ HOSPITAL INPATIENT ☐ HOSPITAL OUTPATIENT ☐ NOT A HOSPITAL PATIENT

HOSPITAL PATIENT DATE OF DISCHARGE ___/___/___

2 Shared Decision Making

Documentation of shared decision making, including a detailed discussion about management options and patient preferences, is required prior to processing the test.

BOTH provider and patient signatures, legible names, and dates are required.

SHARED DECISION MAKING

Patient Acknowledgment: By signing this form, I acknowledge that I have had a detailed discussion with my healthcare provider on the risks and benefits of The 4Kscore Test and reviewed the shared decision aid on the back of this form. This included a discussion of why The 4Kscore Test was being ordered, my other options including prostate biopsy, and potential risks of getting The 4Kscore Test. After this review and discussion, I understand and agree with the recommendation to order The 4Kscore Test.

Print Patient Name: _____ Patient Signature: _____ Date: _____

Physician Acknowledgement: By submitting this test requisition and accompanying sample(s), I certify that a shared decision making discussion occurred with the patient about The 4Kscore Test. This included a discussion of the medical risks and benefits of The 4Kscore Test, other management options including undergoing a prostate biopsy, and potential risks for this management plan. After this discussion, the patient has agreed that The 4Kscore Test is the best option for him.

I authorize and direct you to perform the testing indicated and confirm that; (i) I am authorized by state law to order the test(s) requested herein; (ii) any test requested on this test requisition form is reasonable and medically necessary for the diagnosis and/or treatment of a disease, illness, impairment, symptom, syndrome or disorder; (iii) the test results will aid in determining the medical management and treatment decisions for this patient's condition on this date of service; and (iv) the full and appropriate diagnosis code(s) are indicated to the highest level of specificity.

Print Provider Name: _____ Provider Signature: _____ Date: _____

3 Clinical Information

PLEASE COMPLETE ALL CLINICAL INFORMATION QUESTIONS. This information is required to run the 4Kscore.

- Each question requires only one answer checked.
- **Note:** Q1 confirms the patient had two or more elevated PSA results within the past two years.
- A DRE result (Nodule or No Nodule) is mandatory for all 4Kscore test orders.

CLINICAL INFORMATION REQUIRED TO PERFORM THE 4KSCORE® TEST

1. Clinical Indication for Ordering The 4Kscore Test:

Selecting a value below confirms that the patient had two or more elevated PSA results within the past two years. Note: The 4Kscore Test should only be ordered when medically reasonable for consideration of biopsy after excluding benign cause of PSA elevation.

☐ 45-54 years old and total PSA ≥2 ng/mL ☐ 55-75 years old and total PSA ≥3 ng/mL ☐ ≥76 years old and total PSA ≥4 ng/mL

2. Prostate Biopsy History:

☐ No prior biopsy ☐ Yes, prior negative biopsy ☐ **Yes, prior positive biopsy (4Kscore test will not be performed)**

3. DRE Result:

☐ Nodule ☐ No Nodule

4 4Kscore Test Codes

- Only one 4Kscore test code should be selected.
- **J148-8 is the primary test code to order 4Kscore** (Serum Separator Tube).
- J149-6 should only be selected if the specimen is plasma (K2EDTA Tube).
- J246-3 should only be selected if ordering for a patient with **only one** elevated PSA result within the past two years.

The 4Kscore® Test

J148-8 ☑ The 4Kscore Test (Serum)

J149-6 ☐ The 4Kscore Test (K2EDTA Plasma)

J246-3 ☐ 4Kscore Reflex on age-stratified elevated PSA value (See age-stratified elevated PSA values listed in Clinical Indication for Ordering the 4Kscore Test)

BioReference® OPKO

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