UNITY BY BILLIONTOONE

REQUISITION FORM

1 SELECT TEST PANEL

Samples without a test panel selected will not be processed.

UNITY Complete® Fetal Risk Screen

☐ **UNITY Carrier Screen™** (recessive conditions)
CFTR** • **SMN1** • **HBB** • **HBA

cfDNA fetal risk assay opt-out ☐
if not selected, a separate cfDNA assay will be run for carrier positive singleton pregnancies

☐ **UNITY Aneuploidy™** (chromosomal conditions) singleton pregnancy
T13** • **T18** • **T21** • **sex chromosome aneuploidies (Z36.0)

☐ order twin pregnancy NIPT analysis† T13, T18, and T21 only. Zygosity included.

☐ add 22q11.2 microdeletion†
☐ add fetal RhD for RhD-negative mothers†
☐ opt-out fetal sex

†Includes Aneuploidy NIPT

SAMPLE REQUIRED: TTT / T / TT

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 NIPT *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

5 CLINICAL INFORMATION

Clinic Name *

Clinic Phone | Clinic Fax | Clinic Account Number

Additional Notes

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

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

6 BILLING INFORMATION

Select one option and provide necessary details.

☐ **Bill to Insurance** ☐ 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

Policy Owner | Policy Owner DOB (MM-DD-YYYY)

Relationship to Policy Owner *Select one*
☐ Self ☐ Dependent ☐ Other

☐ **Bill to Patient**

☐ **Bill to Client**

UNITY BY BILLIONTOONE

TEST PANEL	TEST DETAILS	SAMPLE REQUIREMENT
UNITY Complete®	**UNITY Carrier Screen with fetal risk assessment + 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	**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)** • **optional fetal sex reporting** • **optional fetal RhD reporting for RhD-negative pregnant patients** • **optional 22q11.2 microdeletion analysis** • **zygosity determination included for twin pregnancies**	**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 > 10 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 with fetal risk assessment

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