AlloSure® Kidney Test Requisition Form

PLACE ACCESSION LABEL HERE

All items highlighted in blue are required. Missing information may delay testing.

Ordering Clinician: Complete all required sections and sign the requisition.
Phlebotomists: Complete blue boxes to the right.
Lab: Follow accession labeling instructions in collection kit. Add label to top-right corner of this form.
Report Delivery: Via caredxportal.com. Copies available via fax, EMR, and other secure methods.
For help finding a draw center or additional assistance, call (888) 255-6627 or email CustomerCare@CareDx.com

Collection Facility Name		
Collection Date	Collection Time ☐AM ☐PM	Phleb Initials

Patient Information

Patient Last Name	Patient First Name	MI	Unique Patient Identifier (e.g., MRN)
DOB (mm/dd/yyyy) / Patient Sex ☐ Male ☐ Female	Patient Primary Phone	Patient Email	
Patient Address	City	State Zip	☐ Check box if patient is pregnant

Patient Insurance Information

Primary Insurance	Member ID #	Subscriber Name (if different from patient)
Secondary Insurance (if applicable)	Member ID #	Subscriber Name (if different from patient)

Bill to Facility: ☐ Check if patient has Medicare insurance and test was ordered inpatient, or patient coverage is under private insurance case rate.
In such cases, the hospital may be billed for the test.

Test Requested

Test Requested (choose one)
☐ AlloSure Kidney (ICD-10 Z94.0)
☐ AlloSure Other Organ

Reason for Requesting Test (choose one)
For Cause:
☐ Rule out rejection and decide on need for biopsy
☐ Assess for rejection following pre-test assessment of clinical and biological factors
☐ Assist in determining the adequacy of immunosuppression or response to treatment
☐ Assess rejection following inconclusive or unexpected biopsy

Surveillance:
☐ Evaluate for subclinical rejection in asymptomatic patients

Clinical Information

Active Transplant Date (mm/dd/yyyy)

Study Participant ID (if applicable)

Transplant Organ: Indicate all transplanted organ(s) present in patient, including previous kidney transplants and allogeneic bone marrow transplant.
☐ Kidney ☐ Simultaneous Pancreas Kidney
☐ Organ(s) (specify) _____
Transplant Date(s) _____
If multiorgan, choose one: ☐ Same Donor ☐ Different Donor

Donor Relationship to Patient:
☐ Living Related Donor (identify relationship below - required) ☐ Living Unrelated Donor
☐ Deceased Unrelated Donor

☐ Parent ☐ Child ☐ Grandparent ☐ Grandchild ☐ Sibling ☐ Half-sibling
☐ Great Aunt ☐ Great Uncle ☐ Niece ☐ Nephew ☐ Great Niece ☐ Great Nephew
☐ Aunt ☐ Uncle ☐ Cousin ☐ Fraternal Twin
☐ Identical Twin (STOP-Test not intended for Identical Twin)

Additional Kidney ICD-10 Codes (if applicable)
☐ Z48.22 - Encounter for aftercare following kidney transplant
☐ T86.10 - Unspecified complication of kidney transplant
☐ T86.19 - Other complication of kidney transplant

Other ICD-10 Codes (if applicable)
☐ Z48.288 - Encounter for aftercare following multiple organ transplant
☐ Z94.4 - Liver transplant status
☐ Other:
_____
_____
_____

Order Schedule: Choose one option. Order expires 12 months from order date.
☐ Kidney Testing Schedule Post-Transplant: Year 1 Months 1, 2, 3, 4, 6, 9, 12; Year 2+ Quarterly
☐ Custom Order (complete section to the right)
☐ Single Order
For changes to the order, please call CareDx at (888) 255-6627 or email CustomerCare@CareDx.com

Custom Order Schedule

☐ Jan	☐ May	☐ Sep
☐ Feb	☐ Jun	☐ Oct
☐ Mar	☐ Jul	☐ Nov
☐ Apr	☐ Aug	☐ Dec

Expected Date(s) (mm/dd/yyyy)
_____
_____

Additional Information

_____

Ordering Clinician Information

Ordering Clinician	NPI	Clinician Address
Clinic/Institution	Contact Name	Phone

Statement of Medical Necessity Acknowledgment: Your signature constitutes a statement of medical necessity and your attestation that the test was ordered after evaluating its risk/benefit profile, to assist in the evaluation of the transplanted organ for active rejection, is reasonable and medically necessary, and will be used in the clinical management of the patient. Your signature on this form also indicates that the clinician or clinician's delegate has obtained all necessary 1) authorizations from the patient, including informed consent as to the nature of testing, 2) authorizations to release any medical and insurance information to process claims for services provided by CareDx, Inc., and 3) authorizations from patient to assign billing and reimbursement of insurance claims directly to CareDx, Inc. for services rendered.

Authorized Ordering Clinician Signature: _____ **Date:** _____

CareDx Inc. 3260 Bayshore Blvd., Brisbane, California 94005 | P: (888) 255-6627 F: (415) 287-2456 CustomerCare@CareDx.com www.CareDx.com

US-LAB-FRM-TRF-000001 Revision 6 Effective 2026-08