Test Requisition Form

KidneyIntelX™

To avoid delays in receiving test results, all seven sections must be completed.

1. Account Information

CLINIC NAME | RENALYTIX ACCOUNT #

STREET ADDRESS

CITY | STATE | ZIP

PHONE NUMBER | FAX NUMBER | OFFICE CONTACT

EMAIL ADDRESS

Patient Information

PATIENT LAST NAME | FIRST NAME | ☐ MALE ☐ FEMALE

PATIENT ID # / MEDICAL RECORD # | BIRTH DATE (MM/DD/YYYY)

STREET ADDRESS

CITY | STATE | ZIP

DAYTIME PHONE NUMBER | EMAIL ADDRESS

2. Patient Clinical Information

USE VALUES OBTAINED WITHIN THE LAST 12 MONTHS

Estimated Glomerular Filtration Rate (eGFR, ml/min/1.73m²):	RESULT
Urinary Albumin to Creatinine Ratio (UACR, mg/g):	RESULT
Systolic Blood Pressure (SBP, mm of Hg):	RESULT
Hemoglobin A1c (%):	RESULT
Platelet Count (x10³ per µL):	RESULT
Serum Calcium (mg/dL):	RESULT
Aspartate Aminotransferase (AST, IU/Liter):	RESULT

3. Diagnosis Information

This section is not intended to influence the medical judgment of an ordering provider in determining whether this test is right for any particular patient. The following codes are listed as a convenience. Ordering practitioners should report the diagnosis code(s) that best describes the reason for performing the test.

Patient has been diagnosed with both Type 2 Diabetes and Chronic Kidney Disease (CKD):

Check one: ☐ YES ☐ NO

Chronic Kidney Disease (CKD) Select one of the following:

- ☐ N18.1 chronic kidney disease (stage 1)
- ☐ N18.2 chronic kidney disease (stage 2)
- ☐ N18.30 chronic kidney disease (stage 3)
- ☐ N18.31 chronic kidney disease (stage 3a)
- ☐ N18.32 chronic kidney disease (stage 3b)
- ☐ Other(s)

Type 2 Diabetes (T2D): ICD CODE

Other Conditions: ICD CODE

4. Billing Information

Choose one option and provide the necessary information:

☐ **Medicare Part B, Medicaid, or Other Insurance** — Attach a legible copy of both sides of insurance cards. Indicate which is primary. **Testing may be delayed if not received with the sample.**

☐ **Self-Pay** — Patient will be contacted once sample is received to complete this process and set-up payment or payment plan.

☐ **Other Third Party** | PAY SOURCE | CONTACT PHONE #

5. Specimen Information

COLLECTION DATE | COLLECTION TIME | ☐ AM ☐ PM

☐ MOBILE BLOOD DRAW | BLOOD DRAW SERVICE PROVIDER:

☐ SHIP COLLECTION KIT

WARNING Enbrel® interferes with the ability to accurately measure TNFR-2 in patient specimens and is contra-indicated for KidneyIntelX test.

6. Intended Use (Laboratory Developed Test)

KidneyIntelX is indicated for use as an aid to further assess the risk of progressive decline in kidney function within a period of up to 5 years in patients over the age of 21 with Type 2 diabetes and existing chronic kidney disease. Patients with chronic kidney disease will have an estimated Glomerular Filtration Rate [eGFR] of 30-59 ml/min/1.73 m² [G3a, G3b] or eGFR ≥ 60 with albuminuria [UACR] ≥ 30 mg/g [A2, A3]. KidneyIntelX is not intended as a screening or stand-alone diagnostic test.

7. Authorized Signature

PROVIDER FIRST NAME LAST NAME | NPI NUMBER | EMAIL ADDRESS

I am a licensed medical professional. I acknowledge that the KidneyIntelX test requested herein is medically necessary and the patient is eligible for the test. I attest that the medical necessity for tests ordered is documented in the patient's medical record, which will be made available upon request of the performing laboratory and/or third party payer. I hereby order and authorize testing, have explained the nature and purpose of the test to the patient, and have obtained informed consent from the patient to the extent required by law, for Renalytix to proceed with testing; release the test results to the patient or other authorized individual; and obtain reimbursement from the patient's insurance plan for this service.

PROVIDER SIGNATURE | DATE