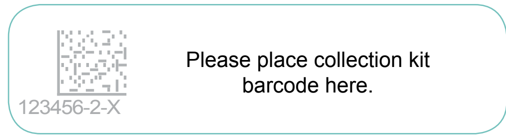
Prospera™
Transplant assessment



YELLOW FIELDS ARE REQUIRED

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

City

State

Zip

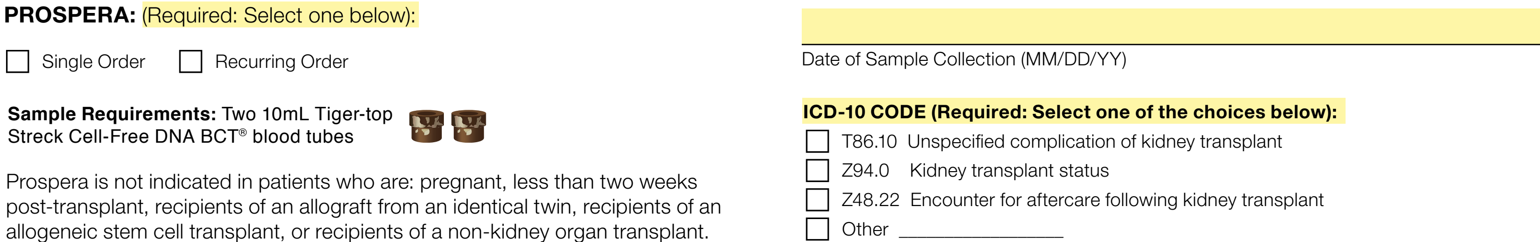
STATEMENT OF MEDICAL NECESSITY: I confirm the testing ordered herein is medically necessary and this patient has been informed of the details of the genetic test(s) ordered, including the risks, benefits, and alternatives, and has consented to testing as may be required by law, including NY CVR §79-l,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

Additional Report Recipient

Fax

Ordering Clinician / Authorized Signature

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

Natera, Inc. | 201 Industrial Road, Suite 410 | San Carlos, CA 94070 | www.natera.com | 1-650-249-9090 | Fax 1-650-730-2272 NAT-801903