April 18, 2025

# New Test Code Available

## Asparaginase Activity

| | |
|---|---|
| Effective Date | Immediately |
| Test Name | Asparaginase Activity |
| Order Code | ASACT |
| Description of Change | As part of our ongoing effort to streamline ordering for high-volume tests previously ordered under the MISC code, we have now assigned a dedicated test code for **Asparaginase Activity.**<br>**What's New:**<br>• The Asparaginase Activity test now has a defined test code: ASACT.<br>• Please begin ordering the Asparaginase Activity test using order code ASACT rather than the generic MISC code.<br>• This update ensures more efficient processing and reduces delays associated with manually reviewed MISC test requests. |
| CPT Code | 82657 |
| Methodology | Spectrophotometry/Absorbance based Enzyme-Coupled Kinetic Reaction |
| Testing Schedule | Routine, 5 times per week |
| Report Availability | 1–3 days |
| **Specimen Requirements** | |
| Minimum Volume | 0.5 mL |
| Container | • Gold Top, Serum Separator<br>• Red Top, Plain |
| Special Instructions | Transport to the laboratory frozen. |
| Collection Instructions | 1. Collect specimen in gold top, serum separator tube or red top, plain tube via venipuncture<br>2. Separate serum from cells within 2 hours of collection<br>3. Transfer 2 mL serum to a plastic aliquot tube<br>4. Freeze sample<br>5. Transport frozen with completed requisition |
| Processing and Submission Instructions | **Submit with completed **Asparaginase Activity Requisition Form**** |

### Additional Information

If you have additional questions regarding this test update, please contact Technical Support between the hours of 8 a.m. and 4:30 p.m. For general questions, Customer Care is available to assist at any time.

### Technical Support / Customer Care

Call 877-402-4221

HNL4.17.25_v1

# ASPARAGINASE REQUISITION FORM

601 Biotech Drive, Suite 301
North Chesterfield, VA 23235
PHONE: (844) 347-2643; FAX: (804) 977-5041
Email: clientservices@grangergenetics.com

## PATIENT INFORMATION

_____

**Last Name*** **First Name*** **M.I.**

_____

Street Address

_____

City State Zip Code

**DOB***: _____ **SEX***: Male ☐ Female ☐

MRN #: _____

Sample ID: _____

***Indicates Required Field**

## PRACTITIONER & INSTITUTION BILLING INFORMATION

Institution Name: _____

**Ordering Practitioner***: _____

_____

**Ordering Practitioner's Signature on this line. Copies of Electronic Orders can be sent in lieu of actual wet signature.**

**Billing Address*:** _____

_____

_____

Phone: _____

***NOTE:** Granger Genetics is **CLOSED** and does not receive samples on **Saturday** or **Sunday**, please plan your shipments accordingly.*

## SAMPLE INFORMATION

**Date of Collection*:** _____ Time of Collection: _____ AM / PM

**See specimen requirements on the back of the page.**

Did the patient receive a previous dose of asparaginase? (Y/N) _____

If Yes Date of last Injection: _____ Time of last Injection: _____ AM / PM

**L-asparaginase administered*: (Please Select One Option)**

☐ Asparlas ☐ Erwinaze ☐ Oncaspar ☐ Rylaze ☐ Other _____

## PLEASE SELECT A TEST TO BE PREFORMED*

○ Asparaginase Activity **OR** ○ Asparaginase Panel (Includes Activity & Antibody)

## REPORT DELIVERY OPTIONS

☐ Fax 1: _____

☐ Fax 2: _____

☐ Web Portal

If not already signed up fill out the information below to receive an email with setup instructions.

Name: _____

Email: _____

## SAMPLE TUBE LABEL AND/OR COMMENTS