

TEMPUS xT REQUISITION FORM

FAX: 708.575.1789 | EMAIL: orders@tempus.com

Associated Study _____
Study ID _____

PATIENT INFORMATION

Last Name		First Name	
Patient Medical Record #	DOB (MM/DD/YYYY)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	
Race / Ethnicity	Email Address		
Street Address, Unit			
City	State	Postal Code	
Country	Primary Phone #		

ORDERING PHYSICIAN INFORMATION

Office / Practice / Institution Name		Clinic
Street Address, Unit		City
State	Postal Code	Country
Phone		Fax
Ordering Physician		
Email Address (required for report delivery)		

GENOMIC SEQUENCING | Please select applicable sequencing options below. The xT sequencing test includes sequencing of tumor and whole transcriptome RNA. RNA may only be sequenced when clinically relevant.

<input type="checkbox"/> xT Panel - targeted panel of 595 genes <i>select one</i> <input type="checkbox"/> Solid tumor + normal (blood or saliva) <input type="checkbox"/> Solid tumor only (when unable to obtain normal matched specimen) <input type="checkbox"/> Hematologic malignancies <input type="checkbox"/> bone marrow <input type="checkbox"/> blood <i>optional</i> <input type="checkbox"/> PD-L1 IHC <input type="checkbox"/> DNA Mismatch Repair Panel (MLH1, PMS2, MSH2, MSH6)	OR	<input type="checkbox"/> xT Panel Package (includes the below) <ul style="list-style-type: none"> • Solid tumor + normal (blood or saliva) • PD-L1 IHC • DNA Mismatch Repair Panel (MLH1, PMS2, MSH2, MSH6) 	Blood / Saliva Specimen Collection Date: _____ <input type="checkbox"/> Previously Submitted
--	-----------	--	---

PATHOLOGY INFORMATION | Complete if pathology report is not attached. Only one sample can be tested per order.

Specimen Availability <input type="checkbox"/> Biopsy Completed (please fill out the section to the right) <input type="checkbox"/> Biopsy Scheduled For: _____ <input type="checkbox"/> Biopsy To Be Scheduled (please follow up with biopsy date)	Hospital / Institution Name _____			
	<table border="1"> <tr> <td>Case # or Date of Collection</td> <td>Block #</td> <td>Alternate Choice (optional)</td> </tr> </table>	Case # or Date of Collection	Block #	Alternate Choice (optional)
Case # or Date of Collection	Block #	Alternate Choice (optional)		

BILLING INFORMATION

ICD-10 Primary Diagnosis Code(s)	Bill Type <input type="checkbox"/> Insurance (must attach copy of card) <input type="checkbox"/> Hospital / Institution <input type="checkbox"/> Medicare - Part B <input type="checkbox"/> Self Pay/International Patient	Patient Status (for Medicare patients) <input type="checkbox"/> Hospital Inpatient - Date of Discharge: _____
Primary Insurance	Policy #	Group #
Policy Holder Name	Policy Holder DOB	Patient Relationship to Policy Holder <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Medical Justification <input type="checkbox"/> Patient newly diagnosed with stage IV non-small cell lung cancer (NSCLC) <input type="checkbox"/> Patient newly diagnosed with cancer of unknown primary (CUP) <input type="checkbox"/> Patient newly diagnosed with selected stage IV rare or uncommon solid tumors for whom very limited or no systemic treatment exists in clinical care guidelines and/or pathways.		
<input type="checkbox"/> Patient newly diagnosed with selected Stage IV solid tumor types having poor prognosis, very limited benefit from standard of care chemotherapies. <input type="checkbox"/> Patient with a stage IV solid tumor who has exhausted the established guideline-driven systemic therapy but desires further treatment. <input type="checkbox"/> Patient newly diagnosed with high grade gliomas. <input type="checkbox"/> Patient with newly diagnosed hematologic malignancies with limited treatment options in defined clinical care guidelines.		

PHYSICIAN SIGNATURE

I certify that I have explained to the patient the purpose, risks and benefits of the test being ordered. My signature below is my certification of medical necessity for the test and further certifies that I have obtained from the patient informed consent that meets the requirements of applicable law for Tempus to: (a) perform the test described in this form; (b) obtain, receive, and release, test results and any corresponding medical information as necessary for reimbursement or the processing of insurance claims; (c) retain samples and information obtained from the patient, including the test results, for an indefinite period of time; (d) use information obtained from the patient and the test results in accordance with applicable law, including de-identifying such information and disclosing the de-identified information for other purposes.

ADDITIONAL PHYSICIAN TO BE COPIED

Name	Email / Fax
Office / Practice / Facility Name	

FORM COMPLETED BY

Name	Email
------	-------

PHYSICIAN SIGNATURE

Ordering Physician Signature	Date (MM/DD/YYYY)
------------------------------	-------------------

SHIPPING LABEL

--

PATHOLOGY RELEASE

Unless you check the following box, you confirm the pathology lab listed in the "Pathology Information" section of the requisition or on the attached pathology report is part of the treatment team and may receive a copy of test results upon its request to Tempus. Check here if the pathology lab is **not** part of the treatment team:

PHENOTYPIC ATTRIBUTES | Please fill in the table below

Cancer Type	Attribute (if cancer type selected)	Notes
Lung	Smoker	<input type="checkbox"/> No <input type="checkbox"/> Yes
Brain	Radiation Exposure	<input type="checkbox"/> No <input type="checkbox"/> Yes
Liver	Hepatitis C Positive	<input type="checkbox"/> No <input type="checkbox"/> Yes
Liver	Hepatitis B Positive	<input type="checkbox"/> No <input type="checkbox"/> Yes

Cancer Type	Attribute (if cancer type selected)	Notes
Breast	Pre-Menopause	<input type="checkbox"/> No <input type="checkbox"/> Yes
Breast	HER2 Status	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
Breast	ER Status	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
Breast	PR Status	<input type="checkbox"/> Positive <input type="checkbox"/> Negative

CLINICAL INFORMATION | Complete if Progress Report is not attached.

Diagnosis	Date of Diagnosis	Cancer Stage (TNM)	Radiation Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes - Start Date: _____ End Date: _____	ECOG Status
Surgical Resection <input type="checkbox"/> No <input type="checkbox"/> Yes - Date: _____ Resection Score: _____		Has the patient had any type of transplant? <input type="checkbox"/> No <input type="checkbox"/> Yes - Type: _____		Relapse / Recurrence <input type="checkbox"/> No <input type="checkbox"/> Yes - Date: _____
Cancer Medication(s)				
Therapy: _____	Start/End Date: _____	-	Response to Therapy: _____	Other Clinically Significant Illnesses: _____
Therapy: _____	Start/End Date: _____	-	Response to Therapy: _____	_____
Therapy: _____	Start/End Date: _____	-	Response to Therapy: _____	<input type="checkbox"/> No previous medications

Patient Consent to Genetic Testing

Your doctor has ordered genomic sequencing and analysis (hereinafter the "Test") to obtain additional information that may inform medical management of your cancer. This document describes the potential risks, benefits, and limitations of the Test. If you have any questions or need additional information, please consult your doctor before signing. You are not required to have this test. If you decide to authorize the Test, please sign and date where indicated at the end of this document.

Purpose & Process

Tempus will perform Next Generation Sequencing ("NGS") and analysis of certain regions of your DNA and RNA that may be associated with your cancer and will report Test results to your doctor. The goal of the Test is to identify key characteristics of your cancer that may inform clinical decision making. Tempus will work with your doctor to obtain tumor samples, normal samples (saliva or blood) and information from your electronic health record. Genetic material, including DNA and RNA, will be obtained from samples, stored, and analyzed. Tempus will compare DNA sequencing results obtained from the tumor cells with those obtained from your normal cells. In order to improve the quality of our testing, Tempus may retain your tissue, cells and/or DNA or RNA extracted from your cells for an indefinite period of time following the testing ordered by your doctor and use leftover materials for internal purposes, including quality assurance and test validation. Tempus may also remove directly identifying information from these materials and use them for research purposes, including future research related to cancer diagnosis, testing and therapies.

Risks, Benefits, & Limitations

Tempus' Test report does not provide any medical diagnosis and does not make any specific treatment recommendations; instead it provides information for your doctor to review. There is no guarantee that performance of NGS will yield clinically relevant information, inform your doctor's clinical decision-making or otherwise lead to any particular or beneficial outcome for you.

Test results may show one or more "actionable" genomic alterations, meaning that there may be FDA-approved therapies available that target your specific type of cancer or that certain clinical trials may be available to you. Knowledge about the effects and meaning of genetic changes is constantly changing. This Test does not examine every possible variant that may exist, and the technology also may not identify all variants related to your cancer, because there is a possibility of testing errors by Tempus and because some biological factors may limit the accuracy of results. Tempus is under no ongoing obligation to update, revisit or later re-evaluate the results of the Test after those results have been made available to your doctor through the test report described above.

Performing the Test on your normal (non-tumor) tissue may reveal health information unrelated to your cancer diagnosis ("incidental findings"). You may learn medical information about yourself that you did not expect, such as learning of an additional diagnosis or a change in your condition, which may or may not be treatable and which may cause you distress just by learning about it. You may choose not to have these additional incidental findings or variants sent to your doctor, and you can do so by selecting the applicable box below. If you want to have these additional results sent to your doctor, Tempus will use its discretion, sending only results that Tempus considers possibly significant at the time it sends the report.

To learn more about genetic testing, you may want to speak with a genetic counselor before and/or after testing. If you want to talk to a genetic counselor, you can ask your doctor to refer you to one. You are required to sign this agreement in order to receive testing from Tempus, and your signature below indicates that you have read and understood the information and are agreeing to have the Test.

Assignment of Insurance Benefits; Authorization; Appointment as Legal Representative

I hereby assign all applicable health insurance benefits and/or insurance reimbursement I have under my health plan(s) to Tempus Labs, Inc. ("Tempus") for services performed by Tempus. I also appoint Tempus as my authorized representative and convey to Tempus, to the full extent permissible under the law, the power to: (1) file medical claims with the health plan; (2) file appeals and grievances with the health plan and/or any agency or governmental body with applicable authority; (3) obtain and release, medical records and insurance information as necessary to process a claim, appeal or grievance; and (4) collect payment of any and all medical benefits and insurance proceeds (including Medicare and Medicaid). The above appointment and conveyance includes all my rights in connection with any claim, right, or cause of action including litigation against my health plan that I may have, including, the right to claim on my behalf, all such benefits, claims, or reimbursement, and to seek any other applicable remedy, including fines.

Specimen Release

By signing below, I authorize the release of my original pathology slides/blocks/clinical specimens and other materials, including extracted DNA and RNA, that are requested by Tempus ("Materials"), and I hereby direct the pathology lab receiving this request to release and provide all such Materials to Tempus. I understand that the Materials may be irreplaceable and could be lost or damaged in handling, transit or when used. I agree to release Tempus and any pathology laboratory releasing such Materials from any claims I may have for any such loss or damage to the Materials.

CONSENT TO TEST

Patient Signature	<p>REQUIRED – CHECK ONE OF THE BOXES BELOW:</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Please indicate your willingness for Tempus to report to your doctor information about incidental findings in your normal sample by checking "YES" or "NO." If you do not select an option, Tempus will report the additional results to your doctor, but only the results that Tempus, at the time of the report, considers to be possibly significant.</p>
Print Name of Patient	
Date (MM/DD/YYYY)	