TEMPUS xT REQUISITION FORM

Targeted panel of 596 genes

FAX: 708.575.1789 | EMAIL: support@tempus.com

Associated Study _____

Study ID _____

PATIENT INFORMATION

Last Name	**First Name**	
Patient Medical Record #	**DOB (MM/DD/YYYY)**	**Sex** ☐ M ☐ 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)		

xT PANEL TEST OPTIONS | The xT sequencing test includes sequencing of tumor and whole transcriptome RNA. RNA may only be sequenced when clinically relevant.

Solid Tumors

Genomic Sequencing

☐ **Tumor + Normal Sample**

☐ **Automatically convert order to xF liquid biopsy** (105 gene panel)* if tissue sample quantity or quality is insufficient for xT testing. Do not attempt to obtain more tissue.

**Requires matched normal blood sample. Not designed for sarcomas, hematologic malignancies, brain tumors, and disease known to be stage I or II*

☐ **Tumor Sample Only** (recommended when unable to obtain normal matched specimen)

IHC Options

☐ **PD-L1 IHC**

PD-L1 clone 22C3 will be used, unless one of the below is specified:

- ☐ **22C3 (Default)**
- ☐ **28-8**
- ☐ **SP142**

☐ **DNA Mismatch Repair Panel** *(MLH1, PMS2, MSH2, MSH6)*

Hematologic Malignancies

☐ Blood

☐ Bone Marrow

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

Tumor Specimen Collection

☐ Biopsy Completed (please fill out the section to the right)

☐ Biopsy Scheduled for: _____

☐ Biopsy to be Scheduled (please follow up with biopsy date)

Pathology Lab Name		
Case Number	**Date of Collection**	**Block #**

NORMAL SAMPLE COLLECTION | When applicable

☐ Blood

☐ Saliva

Collection Date: _____

☐ *previously submitted*

BILLING INFORMATION

Diagnosis	**Date of Diagnosis**	**Originally Diagnosed Stage (TNM)**	**Current Stage (TNM)**

ICD-10 Primary Diagnosis Code(s)	**Bill Type** ☐ Insurance (must attach copy of card) ☐ Hospital/Institution ☐ Medicare - Part B ☐ Self Pay/International Patient	**Patient Status (for Medicare patients)** ☐ Hospital Inpatient - Date of Discharge: _____

Primary Insurance	**Policy #**	**Group #**
Policy Holder Name	**Policy Holder DOB**	**Patient Relationship to Policy Holder** ☐ Self ☐ Spouse ☐ Child ☐ Other

Medical Justification

☐ Patient newly diagnosed with stage IV non-small cell lung cancer (NSCLC)

☐ Patient newly diagnosed with cancer of unknown primary (CUP)

☐ Patient newly diagnosed with high grade gliomas.

☐ 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.

☐ Patient newly diagnosed with selected Stage IV solid tumor types having poor prognosis, very limited benefit from standard of care chemotherapies.

☐ Patient with a stage IV solid tumor who has exhausted the established guideline-driven systemic therapy but desires further treatment.

☐ Patient with newly diagnosed hematologic malignancies with limited treatment options in defined clinical care guidelines.

☐ Other: _____

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.

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.

SHIPPING LABEL

FORM COMPLETED BY

Name
Email

PHYSICIAN SIGNATURE

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

PHENOTYPIC ATTRIBUTES

Cancer Type	Attribute (if cancer type selected)	Notes
Lung	Smoker	☐ No ☐ Yes
Brain	Radiation Exposure	☐ No ☐ Yes
Liver	Hepatitis C Positive	☐ No ☐ Yes
Liver	Hepatitis B Positive	☐ No ☐ Yes

Cancer Type	Attribute (if cancer type selected)	Notes
Breast	Pre-Menopause	☐ No ☐ Yes
Breast	HER2 Status	☐ Positive ☐ Negative
Breast	ER Status	☐ Positive ☐ Negative
Breast	PR Status	☐ Positive ☐ Negative

CLINICAL INFORMATION | Complete if Progress Report is not attached.

Radiation Treatment
☐ No ☐ Yes - Start Date: _____ End Date: _____

Surgical Resection
☐ No ☐ Yes - Date: _____ Resection Score: _____

Has the patient had any type of transplant?
☐ No ☐ Yes - Type: _____

Relapse / Recurrence
☐ No ☐ Yes - Date: _____

ECOG Status

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: _____ ☐ No previous medications

ADDITIONAL PHYSICIAN TO BE COPIED

Name	Email / Fax	Office / Practice / Facility Name

PATIENT CONSENT

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. Tempus will perform its most current version of the Test ordered by 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

Print Name of Patient

Date (MM/DD/YYYY)

REQUIRED – CHECK ONE OF THE BOXES BELOW:

☐ YES ☐ NO

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.

Updated August 22, 2019. The most recent Tempus requisition can be found at Tempus.com/resources