TEMPUS | xG FAMILIAL VARIANT TESTING ORDER FORM — 091421

Familial Variant Testing (i.e. Cascade Testing) is offered at no additional cost for blood relatives (out to 3rd degree) of patients who are found to have a pathogenic or likely pathogenic variant on the Tempus xG test. No-cost testing is offered for 90 days from the original xG report date.

Submit completed forms to: xG-ops@tempus.com or Fax: 800.893.0276

A. PATIENT INFORMATION (Required)

Last Name	First Name	Middle Name

Medical Record #	DOB (MM/DD/YYYY)	Sex ☐ M ☐ F

Email	Phone

Race/Ethnicity

☐ White/Caucasian ☐ Native American ☐ Middle Eastern
☐ Black/African American ☐ East Asian ☐ Ashkenazi Jewish
☐ Hispanic ☐ South Asian ☐ Other _____

Address (Street, Unit)			
City	**State**	**Postal Code**	**Country**

B. ORDERING HEALTHCARE PROFESSIONAL INFORMATION (Required)

Institution Name	
Ordering Professional's Name	
Account #	**NPI #**

Email	Phone	Fax

Address (Street, Unit)	
City	**State**
Postal Code	**Country**

C. PATIENT CANCER HISTORY

☐ No personal history of cancer	ICD-10
Diagnosis	**Age at Diagnosis**
Diagnosis	**Age at Diagnosis**
Diagnosis	**Age at Diagnosis**

D. FAMILY HISTORY

☐ None/No Known Family History ☐ Adopted ☐ Unknown

Relationship	☐ Maternal ☐ Paternal	Relevant History	Age at Diagnosis
Relationship	☐ Maternal ☐ Paternal	**Relevant History**	**Age at Diagnosis**
Relationship	☐ Maternal ☐ Paternal	**Relevant History**	**Age at Diagnosis**
Relationship	☐ Maternal ☐ Paternal	**Relevant History**	**Age at Diagnosis**
Relationship	☐ Maternal ☐ Paternal	**Relevant History**	**Age at Diagnosis**

E. TARGETED VARIANT TESTING

☐ Known Familial Variant(s)

Proband Name	Proband DOB	Relationship to Proband	Proband Accession #

Variant Information (Attaching family member test report recommended) # of Variants: _____

Gene	Coding DNA (c.)	Amino Acid (p.)	Transcript (NM#)
Gene	**Coding DNA (c.)**	**Amino Acid (p.)**	**Transcript (NM#)**
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F. SAMPLE INFORMATION

☐ Blood ☐ Buccal Swab	Date of Collection	***Section A** must be completed for these options:* ☐ Mobile phlebotomy ☐ Send buccal swab kit to patient

Personal history of allogenic bone marrow or peripheral stem cell transplant: ☐ Y ☐ N ***Note:** Using a blood or buccal sample is **not appropriate** for patients who have undergone a bone marrow transplant.*

HEALTHCARE PROFESSIONAL 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.

G. HEALTHCARE PROFESSIONAL SIGNATURE

Healthcare Professional Signature	
Printed Name	**Date (MM/DD/YYYY)**

H. FORM COMPLETED BY

Full Name
Email

Please continue to the following page →

I. BILLING INFORMATION*			
Primary Insurance		**Policy #**	**Group #**
Policy Holder Name	**Policy Holder DOB (MM/DD/YYYY)**	**Patient Status (Medicare Patients)** ☐ Hospital Inpatient - Date of Discharge: _____	
Race/Ethnicity ☐ Insurance (must attach copy of card) ☐ Hospital / Institution ☐ Medicare - Part B ☐ Self Pay/International Patient		**Patient Relationship to Policy Holder** ☐ Self ☐ Spouse ☐ Child ☐ Other _____	

* Not required if order is placed ≤ 90 days from initial family member's (proband) report date. For orders after 90 days, patient self-pay cost is $99 or insurance may be billed.

PATIENT CONSENT

Patient Consent to Genetic Testing

Your healthcare provider has or will order genetic testing that may provide certain hereditary information about you and your family. By signing below, you (or your legally authorized representative) acknowledge receipt of the potential risks, benefits, and limitations of the genetic testing ordered by your healthcare provider, and provide your consent as to the matters listed in this form, including collection, use, retention, maintenance, and disclosure of your DNA samples and the results of any DNA analysis. If you have any questions or need additional information, please consult your healthcare provider before signing.

Testing Process and Purpose

Hereditary genetic testing will be performed on a blood or buccal (cheek) swab sample by GeneDx, a laboratory with whom Tempus has contracted. GeneDx may retain your tissue, cells and/or DNA extracted from your cells for an indefinite period of time following the testing ordered by your healthcare provider. GeneDx and Tempus may also remove personally identifying information from genetic testing materials in accordance with applicable law. The de-identified health information may be used for different purposes. It may be shared with others, like universities, hospitals, and companies, who research the causes of disease, develop new drugs and therapies, and help pay for the cost of health care. Tempus or others may use the de-identified information for any business purpose permitted by federal law, including but not limited to health care operations, commercial development, and research.

The purpose of this test is to obtain information to help determine if you have a genetic variant associated with a genetic condition and/or to determine the chance that you may develop or pass on a genetic condition in the future.

There are several types of genetic test results that may be reported, including:

- Positive: A variant was found in the DNA that is associated with a genetic condition. This result may be used by your healthcare provider to make additional medical management and screening recommendations. This result may have implications for other family members. For example, if you are found to carry a genetic variant in any of the genes analyzed, your family members may also carry the same variant identified in you.
- Negative: No variants were found in the DNA that are associated with a genetic condition. This reduces but does not eliminate the possibility that there is a genetic variant associated with a genetic condition. A healthcare provider or genetic counselor may discuss more genetic testing now or in the future.
- Variant of uncertain significance (VUS): A variant in the DNA was found, however, based on information currently available, it is not yet known if this variant is associated with a genetic condition or not. Your healthcare provider may make cancer screening and medical management recommendations based on your personal and/or family history. Genetic testing of other family members may be suggested to help clarify these results.

Risks & Limitations

- The test reports do not provide any medical diagnosis and do not make any specific treatment recommendations; instead they provide information for your health care provider to review.
- There is no guarantee that performance of a genetic test will yield clinically relevant information, inform your healthcare provider's clinical decision-making, or otherwise lead to any particular or beneficial outcome for you. This test does not examine every possible genetic variant that may exist; this may be due to limitations in current medical knowledge or testing technology.
- Test results may reveal genetic information that may impact your ongoing healthcare management. Knowledge about these facts and the meaning of genetic variants is constantly changing.
- Rarely, genetic testing may reveal a genetic variant or change that is not related to the original reason for ordering the test (called an "incidental finding"). This information may be included on your genetic testing report.
- I understand that there is a possibility that, if multiple family members are tested, this test may reveal that the true biological relationships in a family are not as I believed them to be. This includes detection of non-paternity (the reported father is not the biological father) and consanguinity (the parents are related by blood). I understand these findings will be reported to the healthcare provider who ordered the test.
- While genetic testing is highly accurate, inaccurate results may occur. These could be due to mislabeled samples, inaccurate reporting of clinical/medical information, rare technical errors, or other reasons.
- I understand that, in rare cases, this molecular genetic test may require an additional blood or buccal sample to obtain accurate results.

Patient Confidentiality and Genetic Counseling

It is recommended that you consult with a genetic counselor or your healthcare provider before consenting to genetic testing. It is also advisable to speak with a genetic counselor or your healthcare provider about your results.

It is your responsibility to consider the possible impact of genetic test results as they pertain to insurance rates, obtaining disability or life insurance and employment. The Genetic Information Nondiscrimination Act (GINA), a federal law, provides some protections against genetic discrimination.

Assignment of Insurance Benefits; Authorization; Appointment as Legal Representative

By signing below, you hereby assign all applicable health insurance benefits and/or insurance reimbursement you have under your health plan(s) to Tempus Labs, Inc. ("Tempus") for services performed by Tempus. You also appoint Tempus as your 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 of your rights in connection with any claim, right, or cause of action including litigation against your health plan that you may have, including, the right to claim on your behalf, all such benefits, claims, or reimbursement, and to seek any other applicable remedy, including fines.

Patient Signature	**Patient DOB (MM/DD/YYYY)**
Print Name of Patient	**Date (MM/DD/YYYY)**

Please send completed forms by email to xG-ops@tempus.com or fax to 800.893.0276.
Last updated September 14, 2021. The most recent Tempus requisition can be found at Tempus.com/resources.

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