TEMPUS REQUISITION FORM STANDARD – 012122

Phone: 800.739.4137 | Fax: 800.893.0276 | support@tempus.com

Associated Study _____ Study ID _____

A. PATIENT INFORMATION (REQUIRED)

Last Name	First Name	Middle Name
DOB (MM/DD/YYYY)	Patient Medical Record #	Sex ☐ M ☐ F
Race / Ethnicity	Email Address	
Street Address, Unit		
City	State	Postal Code
Country	Primary Phone #	

B. ORDERING PHYSICIAN INFORMATION (REQUIRED)

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

C. TESTING OPTIONS

	Optional add-on tests:	MMR IHC	PD-L1 IHC[1]	HRD	Tumor Origin	DPYD
☐ xT **xT Solid Tumor + Normal* – 648 genes** ↳ ☐ xF Add Concurrent xF Liquid Biopsy* – 105 genes	*(Uses normal match blood sample)*	■	■	■	■	■
☐ xT **xT Solid Tumor Only* – 648 genes**		■	■	■	■	
☐ xT **xT Hematologic Malignancy – 648 genes**	*(Blood, FFPE, or Bone Marrow Aspirate)*					
☐ xF **xF Liquid Biopsy* – 105 genes**	*(Non-hematologic malignancies only)*					
☐ xG **xG+ (extended hereditary cancers) – 88 genes** ☐ xG **xG (common hereditary cancers) – 52 genes**	*(Powered by GeneDx)*					

Conversion to xF Liquid Biopsy 105 genes — If concurrent testing is not selected, you can opt-in to one of the following:

☐ Convert to xF immediately

☐ Convert to xF after additional tissue request

[1]**PD-L1 clone 22c3 is the default.** For different clones, please select all that apply:

☐ 22c3 ☐ 28-8 ☐ SP142

For cancers determined to be ovarian, breast, prostate or pancreatic (at pathology review), this includes an order for a separate BRCA1/2 - Tumor Analysis.

D. SPECIMEN RETRIEVAL

xT Solid Tumor

Option 1 – ☐ Specific specimen requested *(Please provide specimen details below).* Option 2 – ☐ Let the submitting pathologist choose specimen. Option 3 – ☐ Biopsy to be scheduled for: _____

Pathology Lab Name			
Case Number	Block #	Solid Tumor Collection Date	☐ Check here if the pathology lab is ***not*** part of the treatment team.

xT Normal	☐ Blood ☐ Saliva	Date of Collection	Section A must be completed for these options.	☐ Mobile phlebotomy ☐ Send saliva kit to patient *for xT Normal only*	☐ Previously submitted
xF Liquid Biopsy	☐ Blood				
xT Hematologic Malignancy	☐ Blood (EDTA) ☐ FFPE (Bone Marrow Biopsy, Bone Marrow Clot, Lymph Node, or other involved tissue) ☐ Bone Marrow Aspirate (EDTA)	Date of Collection	Section A must be completed for these options. *Please see specimen instructions for details.*	☐ Mobile phlebotomy ☐ Send saliva kit to patient	
xG Hereditary Cancer Panel	☐ Blood ☐ Buccal Swab	Date of Collection	Section A must be completed for these options.	☐ Mobile phlebotomy ☐ Send buccal swab kit to patient	

E. CURRENT DIAGNOSIS

☐ NSCLC ☐ Melanoma ☐ Prostate ☐ Colorectal Carcinoma ☐ Ovarian ☐ Breast ☐ Other: _____

Disease Status *(select all that apply):* ☐ Metastatic ☐ Refractory ☐ Relapse ☐ Other: _____

ICD-10 Primary Diagnosis Code(s)	Additional Details	Stage

F. BILLING INFORMATION

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

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.

G. PHYSICIAN SIGNATURE

Ordering Physician's Signature	Date (MM/DD/YYYY)
Printed Name	

H. FORM COMPLETED BY

Name
Email

Phone: 800.739.4137 | Fax: 800.893.0276 | support@tempus.com
600 West Chicago Avenue Suite 510, Chicago, IL 60654 | tempus.com

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

I. PHENOTYPIC ATTRIBUTES

Cancer Type	Attribute (if cancer type selected)	Notes	Cancer Type	Attribute (if cancer type selected)	Notes
Lung	Smoker	☐ No ☐ Yes	Breast	Pre-Menopause	☐ No ☐ Yes
Brain	Radiation Exposure	☐ No ☐ Yes	Breast	HER2 Status	☐ Positive ☐ Negative
Liver	Hepatitis C Positive	☐ No ☐ Yes	Breast	ER Status	☐ Positive ☐ Negative
Liver	Hepatitis B Positive	☐ No ☐ Yes	Breast	PR Status	☐ Positive ☐ Negative

J. 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)

☐ No previous medications

Therapy: _____ Start/End Date: _____ - _____ Response to Therapy: _____

Therapy: _____ Start/End Date: _____ - _____ Response to Therapy: _____

Therapy: _____ Start/End Date: _____ - _____ Response to Therapy: _____

Other Clinically Significant Illnesses: _____

K. ADDITIONAL PHYSICIAN TO BE COPIED

Name	Email / Fax	Office / Practice / Facility Name