TEMPUS REQUISITION FORM NYS – 033022

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]
☐ **xT Solid Tumor + Normal* – 648 genes** ↳ ☐ Add Concurrent xF Liquid Biopsy* – 105 genes	*(Uses normal match blood sample)*	☐	☐
☐ **xT Solid Tumor Only* – 648 genes**		☐	☐
☐ **xT Hematologic Malignancy – 648 genes**	*(Blood, FFPE, or Bone Marrow Aspirate)*		
☐ **xF Liquid Biopsy* – 105 genes**	*(Non-hematologic malignancies only)*		
☐ **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

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.[2]

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.

[2] **PATHOLOGY RELEASE (SECTION D)** Unless the box in "Section D" has been checked, 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.

G. PHYSICIAN SIGNATURE

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

Printed Name

H. FORM COMPLETED BY

Name

Email

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600 West Chicago Avenue Suite 510, Chicago, IL 60654 | tempus.com

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

PATIENT CONSENT

Patient Consent to Genetic Testing

Your doctor has ordered genomic sequencing and analysis (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 that may be associated with your cancer and will report Test results to your doctor. Tempus will perform its most currently approved 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 and/or normal samples (saliva, blood, and/or a buccal swab) and information from your electronic health record. DNA will be obtained from samples, stored, and analyzed. In order to improve the quality of our testing, Tempus may retain your tissue, cells and/or DNA 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 associated clinical information and use them for research purposes, including future research related to cancer diagnosis, testing and therapies.

☐ I do not wish for Tempus to retain any residual material from my specimen(s) and instead wish for them to be destroyed at the end of the testing process or not more than sixty days after the sample was taken, in accordance with New York State Law.

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 the Test 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 Tests on your normal (non-tumor) tissue, including the xG Test, may reveal certain personal health information about you or information about your genetic profile that is unrelated to your cancer diagnosis, such as hereditary information, additional diagnoses, or changes in your condition ("incidental findings"). The Test Reports will include information about incidental findings. In each case where incidental findings are reported, you may learn medical information about yourself (or your family) that you did not expect. You may want to discuss this information with your physician or a genetic counselor. If you want to talk to a genetic counselor, you can ask your doctor to refer you to one, or you can find contact information on the Test Report that Tempus will make available to you or your doctor. These incidental findings may be important to determining an appropriate course of treatment; however, you are not required to receive them. Your signature below indicates that you have read, understood, and agree to receive incidental findings related to the Tests ordered by your physician.

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.

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

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