TEMPUS REQUISITION FORM INTERNATIONAL — 2022.11.30

Phone: +1 800.739.4137 | Fax: +1 800.893.0276 | support@tempus.com

A. PATIENT INFORMATION (REQUIRED)

Last Name	First Name	Middle Name
DOB (DD/MM/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)

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

C. TESTING OPTIONS (REQUIRED)

	Optional add-on tests:	MMR IHC	PD-L1 IHC[1]	HRD	Tumor Origin	DPYD	UGT1A1
☐ **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**	*(FFPE)*						
☐ **xF Liquid Biopsy – 105 genes**	*(Non-hematologic malignancies only)*						
☐ **xE Whole Exome Tumor + Normal* – 19,433 genes**	*(Requires normal match sample)*						

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 ☐ SP263

D. SPECIMEN RETRIEVAL (REQUIRED)

xT or xE 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 or xE Normal	☐ Blood ☐ Saliva	Date of Collection	Section A must be completed for these options. ☐ Send saliva kit to patient *for xT or xE Normal only*	☐ Previously Submitted
xF Liquid Biopsy	☐ Blood			
xT Hematologic Malignancy	☐ FFPE (Bone Marrow Biopsy, Bone Marrow Clot, Lymph Node, or other involved tissue)	Date of Collection	Section A must be completed for these options. *Please see specimen instructions for details.* ☐ Send saliva 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) — REQUIRED	Additional Details	Stage

F. BILLING INFORMATION

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

Bill Type ☐ Insurance ☐ Hospital/Institution ☐ Self Pay/International Patient

PHYSICIAN SIGNATURE I certify that the patient has received an explanation of the purpose, risks, and benefits of the ordered test(s). My signature below certifies medical necessity of the test(s) (including that the test results will inform the treatment plan) and that the patient has provided informed consent that meets the requirements of applicable law for Tempus or its reference lab to: (a) collect and use the patient's samples (including genetic material) and health information and perform the ordered test(s); (b) obtain, receive, and release health information (including test results) as necessary for reimbursement or the processing of insurance claims; (c) retain and use samples and health information for an indefinite period of time in accordance with applicable law; and (d) de-identify such samples and information and use and share the resulting de-identified samples and information in accordance with applicable law.

G. PHYSICIAN SIGNATURE (REQUIRED)

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

H. FORM COMPLETED BY

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

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PATIENT IDENTIFIERS		
Print Name of Patient	Patient DOB (DD/MM/YYYY)	Date (DD/MM/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	Surgical Resection	
☐ No ☐ Yes — Start Date: ☐ End Date:	☐ No ☐ Yes — Date:	Resection Score:
Has the patient had any type of transplant?	**Relapse / Recurrence**	**ECOG Status**
☐ No ☐ Yes — Type:	☐ No ☐ Yes — Date:	

Cancer Medication(s)

☐ No previous medications

Therapy:	Start Date:	End Date:	Response to Therapy:
Therapy:	Start Date:	End Date:	Response to Therapy:
Therapy:	Start Date:	End Date:	Response to Therapy:

Other Clinically Significant Illnesses:

K. ADDITIONAL PHYSICIAN TO BE COPIED

Name	Email / Fax	Office / Practice / Facility Name

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