TEMPUS | Lilly

REQUISITION FORM

Lilly Lung Cancer NGS Program

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tempus.com/LillyLungProgram

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 #	

ORDERING PHYSICIAN INFORMATION (REQUIRED)

Office/Practice/Institution Name/Clinic		Account #
Street Address, Unit		City
State	Postal Code	Country
Phone #	Fax	
Ordering Physician's Name	NPI #	
Email Address (REQUIRED FOR REPORT DELIVERY)		

PROGRAM ELIGIBILITY CRITERIA

Patients must meet all of the following criteria to be eligible:

- Patient has advanced or metastatic NSCLC
- Patient lives and receives treatment in the United States or a US Territory (including Puerto Rico, Guam, and Marshall Islands)
- Patient does not have a known molecular biomarker from a prior test
- Patient has not had prior comprehensive biomarker testing
- Patient has not previously been tested under this Program

TESTING OPTIONS

☐ **xT Solid Tumor + Normal (648 genes)**

Matched normal sample to improve accuracy of somatic variant calls.

If blood is not received, Tempus will proceed with tissue only testing.

☐ **PD-L1 Clone 22C3**

Conversion to xF Liquid Biopsy (105 genes)

Conversion to xF Liquid Biopsy is included in the Program when tissue is insufficient.

Opt-in to one of the following:

☐ Convert to xF immediately

☐ Convert to xF after additional tissue request

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 #	Date of Collection	☐ Check here if the pathology lab is ***not*** part of the treatment team.

xT Normal

☐ Blood	Date of Collection	Patient Information must be completed for these options: ☐ Mobile phlebotomy	☐ Previously submitted

PHYSICIAN SIGNATURE

I certify that I have explained to the patient the purpose, risks and benefits of the test(s) being ordered. My signature below is my certification of medical necessity for the test and further certifies that I am authorized to order the test(s) and 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; and (c) collect, use, and retain samples and information obtained from the patient, including the test results, for an indefinite period of time, including de-identifying such information and disclosing the de-identified information for other purposes. I also agree to the terms in the Program Description.

Program Description

- Patients with advanced/metastatic Non-small Cell Lung Cancer (NSCLC) who have not had prior comprehensive biomarker testing, have not previously been tested under this program, and who live and receive treatment in the United States or a US territory are eligible.
- Eligible patients may receive one xT test (with reflex to xF after one tissue request) and one PD-L1 IHC test (22c3), at no cost, for the purpose of determining whether or not the patient has a genomic variant or biomarker. The ordering provider has made the patient aware that Lilly is financially supporting the ordered tests. No patient, health care program, or beneficiary will be billed for these tests.
- The ordering provider shall not be compensated any fees in connection with this testing, such as for specimen collection, handling, or data reporting. Ordering provider identifying information may be shared with Lilly.
- Healthcare professionals and patients who use this program have no obligation to recommend, purchase, order, prescribe, promote administer, use or support any Lilly or Tempus products or services.
- Lilly and Tempus reserve the right to rescind, revoke, or amend the program for any reason without notice. Program is not valid where prohibited by law. Tempus will not share protected health information with Lilly as part of this program.

PHYSICIAN SIGNATURE

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

FORM COMPLETED BY (IF DIFFERENT FROM PHYSICIAN)

Name
Email

PATIENT NOTICE AND CONSENT

If you are a patient in AK, CA, FL, GA, MI, MN, NE, NJ, OR, SD, TX, or VT, or your health care provider asks you to sign, please sign below.

Your health care provider has or will order one or more tests offered by Tempus (the "Tests"). The Test reports do not provide a definitive medical diagnosis or make any specific treatment recommendations; instead they provide information for your healthcare provider to review. There is no guarantee that performance of a Test will yield clinically relevant information, inform your health care provider'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 a specific disease subtype, certain clinical trials may be available to you, or genetic information that may impact your ongoing health care management. Knowledge about these facts and the meaning of genetic changes is constantly changing. The Tests do not examine every possible genetic variant that may exist, and the Tests also may not identify all variants related to you or your disease, because there is a possibility of testing errors and because some biological factors may limit the accuracy of results. Tempus is not obligated to update, revisit or later re-evaluate the results of the Tests after those results have been made available to your healthcare provider. Test results may reveal certain personal health information about you or information about your genetic profile that is unrelated to your current diagnosis, such as hereditary information or additional diagnoses ("incidental findings"). If 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 doctor 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 healthcare provider.

You authorize release of pathology tissue specimens, blood, saliva, and other materials, including extracted DNA and RNA, requested by Tempus ("Materials") to conduct the Tests, and direct the applicable pathology lab to release all such Materials to Tempus. For genetic Tests that require Materials, genetic Material including DNA and/or RNA will be obtained, stored, and analyzed, by Tempus and/or a reference lab. You understand that the Materials may be irreplaceable and could be lost or damaged in handling, transit or when used. You agree to release Tempus, and any pathology laboratory releasing such Materials, from any claims for any such loss or damage to the Materials. The Tests will generate health data about you and Tempus or the reference lab may receive health data from your medical record in connection with the Tests. Your identifiable data is subject to legal requirements regarding its use and protection. Tempus may use and disclose the Test results and your other health data as described in its notice of privacy practices (NPP). Tempus' current NPP, which includes information about how de-identified DNA analysis and other health data may be commercially used and shared in or out of the United States with life science companies or others, is at https://www.tempus.com/notice-of-privacy-practices/.

Leftover Materials may be retained indefinitely and used and shared for quality, test validation, and other purposes described in the NPP, some of which may involve DNA or RNA analysis. Third parties receiving de-identified data or Materials are prohibited from using it to re-identify you.

By signing below, you acknowledge that you have read (or have had read to you) and understand the information provided above; you understand that the Tests are voluntary and you may choose not to have any Test; and you consent to the genetic testing and to the other matters listed, including collection, use, retention, maintenance, and disclosure of your Materials and the results of any DNA analysis. If law requires you to consent to these terms but you have been unable to sign, provision of your Materials to Tempus indicates your consent. Revisions to this form are void. If you are signing on behalf of the patient, you further certify that you have legal authority to consent on behalf of the patient. Please consult your health care provider if you have questions.

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

