TEMPUS TEST REQUISITION FORM — 2023.10.09

Phone: 800.739.4137 | Fax: 800.893.0276 | support@tempus.com
If information is incomplete or missing, testing may be delayed.

Associated Study	Study ID

A. PATIENT INFORMATION

Last Name	MI	First Name

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

Address (Street, Unit)	City	State	Postal Code	Country

B. ORDERING PHYSICIAN INFORMATION

Ordering Physician (full legal name)	NPI #

Facility Name	Tempus Account #	Email (required for report delivery)	Fax

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

Additional person to be copied

Name	Email/Fax

Facility Name

Form completed by

Name	Email/Fax

Facility Name

C. TESTING OPTIONS

Common test combinations	Test descriptions	Specimen required
xT (DNA) & xR (RNA): ☐ **Solid Tumor/Normal**	xT: 648-gene DNA sequencing test with normal match; xR: whole transcriptome RNA sequencing test.	FFPE Tissue; Normal: Blood or Saliva
☐ **Add xF liquid biopsy at time of order, based on the following:** I believe it is medically necessary to order a liquid biopsy test concurrently with a solid tumor tissue test because of one or more of the following reasons: **(a)** guidelines support the use of testing in this disease state; **(b)** turnaround time for tissue result may delay a treatment decision for my patient; **(c)** the tissue is at risk to fail (e.g. small tissue, archived tissue) and I may not have a timely result to make a treatment decision for my patient; **(d)** genomic heterogeneity may cause the patient's available tissue to not be completely representative, and I want to make sure I have a complete mutation profile.		
If I have not already ordered an xF test above, I opt to convert my xT solid tumor order to an xF liquid biopsy test if necessary: ☐ By converting immediately *OR* ☐ After an additional tissue request is attempted		
xT (DNA) & xR (RNA): ☐ **Solid Tumor**	xT: 648-gene DNA sequencing test; xR: whole transcriptome RNA sequencing test.	FFPE Tissue
xT (DNA) & xR (RNA): ☐ **Heme**	xT: 648-gene DNA sequencing test; xR: whole transcriptome RNA sequencing test.	FFPE Tissue, Blood (EDTA), or Bone Marrow Aspirate (EDTA)
Individual test options		
xR (RNA Only): ☐ **Solid Tumor** *OR* ☐ **Heme**	Whole transcriptome RNA sequencing test.	FFPE Tissue, Blood (EDTA), or Bone Marrow Aspirate (EDTA)
xT (DNA Only): ☐ **Solid Tumor** *OR* ☐ **Heme**	648-gene DNA sequencing test.	FFPE Tissue, Blood (EDTA), or Bone Marrow Aspirate (EDTA)
xF (Liquid Biopsy): ☐	105-gene liquid biopsy test for solid tumors.	Blood (Streck)
xG (Hereditary): ☐ *OR* **xG+ (Hereditary):** ☐	xG: 52-gene common or xG+: 88-gene extended hereditary cancer test, powered by GeneDx.	Blood (EDTA) or Buccal Swab

Optional add-on tests (select all that apply):

xT Solid Tumor, xR LDT FFPE Tissue

- ☐ PD-L1 IHC:
  - ☐ 22C3 **DEFAULT**
  - ☐ 28-8
  - ☐ SP142
  - ☐ SP263
- ☐ MMR IHC
- ☐ HRD*
- ☐ Tumor Origin (RNA)
- ☐ PurIST℠ (RNA, Panc)

* *Normal sample is required for ovarian or breast cancers.*

xT Normal Blood or Saliva

- ☐ DPYD
- ☐ UGT1A1

D. SPECIMEN RETRIEVAL

See Tempus' specimen guidelines for collection instructions and further details.

☐ FFPE Tissue

- ☐ **Option 1:** Specific specimen requested
- ☐ **Option 2:** Let the submitting pathologist choose specimen
- ☐ **Option 3:** Biopsy to be scheduled for:

Pathology Lab (Name, City)

Case Number	Block #	Date of Collection

☐ Blood

☐ Mobile phlebotomy ☐ Sample previously submitted

Date of Collection:

☐ Saliva

☐ Send saliva kit to patient

Date of Collection:

☐ Bone Marrow Aspirate

Date of Collection:

☐ Buccal Swab

☐ Send buccal kit to patient

Date of Collection:

E. CURRENT DIAGNOSIS

☐ Breast ☐ NSCLC ☐ Pancreatic ☐ Other:
☐ Colorectal ☐ Ovarian ☐ Prostate

Primary ICD-10 Codes (C & D codes only)

Stage ☐ I ☐ II ☐ III ☐ IV ☐ Other:

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

Has the patient had any type of transplant?
☐ No
☐ Yes —Type:

Attachments
☐ Copy of patient's progress notes and/or medical records.
☐ Copy of recent pathology report.
☐ Copy of insurance card.

F. BILLING INFORMATION

Primary Insurance Plan Name	Policy #	Group#	Policy Holder Name	Policy Holder DOB

Patient Relationship to Policy Holder
☐ Self ☐ Spouse ☐ Child ☐ Other:

Bill Type:
☐ Insurance ☐ Hospital/Institution ☐ Self pay/International

Patient Status (for Medicare patients)
☐ Hospital Inpatient Date of discharge:

G. PHYSICIAN SIGNATURE AND CONSENT

My signature below certifies that **(1)** the patient has received an explanation of the purpose, risks, and benefits of the ordered test(s); **(2)** the ordered test(s) are medically necessary because the patient has been diagnosed with a cancer that is either recurrent, relapsed, refractory, metastatic, or advanced stage, and the test results will inform the patient's treatment plan; and **(3)** 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.

Ordering Physician Signature

Printed Name (full legal name)	Today's Date (MM/DD/YYYY)

The following fields are for xG+ or xG orders ONLY. Disregard if not testing for hereditary cancers.

H.RELEVANT CLINICAL HISTORY *(Previous cancer diagnosis, GI polyps, etc.)*

I.FAMILY HISTORY

☐ None/No known family history ☐ Unknown ☐ Adopted

Relationship to patient	Maternal	Paternal	Age at diagnosis	Details of relevant history
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		

J.ANCESTRY

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

K.BONE MARROW TRANSPLANT

Personal history of allogenic bone marrow or peripheral stem cell transplant: ☐ Yes ☐ No

Note: Using a blood or saliva sample is not appropriate for patients who have undergone an allogenic bone marrow or peripheral stem cell transplant.

L.PRIOR PERSONAL OR FAMILY HISTORY OF GENETIC TESTING

☐ No personal or family history of molecular and/or genetic testing.

Relationship to patient: ☐ Self ☐ Family member:

☐ Germline testing
Test performed: Results:

Microsatellite instability analysis:
☐ Stable (MSS)
☐ Unstable/High (MSI-High)
☐ Unstable/Low (MSI-Low)

☐ Somatic/tumor testing
Test performed: Results:

☐ Immunohistochemical staining
Proteins present: Proteins absent:

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