TEMPUS International Requisition Form — 2024.02.28

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If information is incomplete or missing, testing may be delayed.

A. PATIENT INFORMATION

Last Name	MI	First Name

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

Address (Street, Unit)	City	State	Postal Code	Country

B. ORDERING PHYSICIAN INFORMATION

Distributor	Ordering Physician (full legal name)	Phone

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

Facility Address (Street, Unit)	City	Postal Code	Country

Additional person to be copied

Name	Email/Fax	Facility Name

C. TESTING OPTIONS

Common test combinations	Test descriptions	Specimen required	Optional add-on tests (select all that apply):
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	**xT Solid Tumor, xR LDT FFPE Tissue** ☐ PD-L1 IHC: ☐ 22C3 DEFAULT ☐ 28-8 ☐ SP142 ☐ SP263 ☐ MMR IHC ☐ HRD* ☐ Tumor Origin (RNA) ** Normal sample is required for ovarian or breast cancers.*
☐ **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.			**xT Normal Blood or Saliva** ☐ DPYD ☐ UGT1A1
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	
xE (DNA) & xR (RNA): ☐ **Solid Tumor/Normal**	xE: over 19,000-gene whole exome DNA sequencing test with normal match; xR: whole transcriptome RNA sequencing test.	FFPE Tissue; Normal: Blood or Saliva	
Individual test options			
xR (RNA Only): ☐ **Solid Tumor**	Whole transcriptome RNA sequencing test.	FFPE Tissue	
xT (DNA Only): ☐ **Solid Tumor**	648-gene DNA sequencing test.	FFPE Tissue	
xF (Liquid Biopsy): ☐ ***OR*** **xF+ (Liquid Biopsy):** ☐	xF: 105-gene or xF+: 523-gene liquid biopsy test for solid tumors.	Blood (Streck)	
xE (DNA Only): ☐ **Solid Tumor/Normal**	Over 19,000-gene whole exome DNA sequencing test with normal match.	FFPE Tissue; Normal: Blood or Saliva	

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**	☐ **Saliva**
☐ Sample previously submitted Date of Collection:	☐ Send saliva 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 ☐ III ☐ Other: ☐ II ☐ IV	
Disease Status (select all that apply): ☐ Metastatic ☐ Relapse ☐ Other: ☐ Refractory ☐ Recurrent	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.	

F. BILLING INFORMATION

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

Patient Relationship to Policy Holder	Bill Type:
☐ Self ☐ Spouse ☐ Child ☐ Other:	☐ Insurance ☐ Hospital/Institution ☐ Self pay/International

G. PHYSICIAN SIGNATURE AND CONSENT

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 further certifies that I am authorized to order the test(s) 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 (if applicable); and (c) collect, use, and retain samples and information obtained from the patient, all in accordance with the Tempus Consent to Genomic Testing form signed by the patient.

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