TEMPUS | REQUISITION FORM — 100421

FAX: 800.893.0276 | EMAIL: 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

Individual Test Options	Optional add-on tests → HRD	PD-L1 IHC[1]	MMR IHC	Tumor Origin	DPYD
☐ xT Solid Tumor + Normal*	☐	☐	☐	☐	☐
↳ ☐ Add xF Liquid Biopsy (concurrent testing)* *Uses the same normal match blood sample*					
☐ xT Solid Tumor Only*	☐	☐	☐	☐	
☐ xT Hematologic Malignancy* *Peripheral blood or bone marrow*					
☐ xF Liquid Biopsy Only* *Non-hematologic malignancies only*					
☐ xG Hereditary Cancer Panel *Powered by GeneDx*					

Conversion to xF Liquid Biopsy — 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

For cancers determined to be ovarian, breast, prostate or pancreatic (at pathology review), this includes an order for a separate BRCA1/2 - Tumor Analysis.

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.

xT Normal / xF Liquid Biopsy	*Choose one:* ☐ Blood ☐ Saliva *for xT Normal only*	Date of Collection	*Section A must be completed for these options:* ☐ Mobile phlebotomy ☐ Send saliva kit to patient *for xT Normal only*	☐ Previously submitted
xT Hematologic Malignancy	☐ Blood *(EDTA)* ☐ FFPE *(i.e. Bone marrow, clot, lymph node)* ☐ Bone Marrow Aspirate *(EDTA)*	Date of Collection	*Section A must be completed for these options:* ☐ Mobile phlebotomy ☐ Send saliva kit to patient	*Please see specimen instructions for details.*
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) ☐ Medicare - Part B ☐ Hospital / Institution ☐ 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.

G. PHYSICIAN SIGNATURE

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

H. FORM COMPLETED BY

Name
Email

I. PHENOTYPIC ATTRIBUTES

Cancer Type	Attribute (if cancer type selected)	Notes
Lung	Smoker	☐ No ☐ Yes
Brain	Radiation Exposure	☐ No ☐ Yes
Liver	Hepatitis C Positive	☐ No ☐ Yes
Liver	Hepatitis B Positive	☐ No ☐ Yes

Cancer Type	Attribute (if cancer type selected)	Notes
Breast	Pre-Menopause	☐ No ☐ Yes
Breast	HER2 Status	☐ Positive ☐ Negative
Breast	ER Status	☐ Positive ☐ Negative
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)

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: _____

☐ No previous medications

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 tests (the "xT Test" or the "xF Test") and/or genetic testing (the "xG Test") to obtain additional information that may inform medical management of your cancer or general health. The xT, xF, and xG Tests may provide certain hereditary information about you and your family. You are not required to receive this hereditary (or "germline") information, although it may assist your physician in determining an appropriate course of treatment. This document describes the potential risks, benefits, and limitations of the Tests. By signing below, you are providing consent to run a genetic test that may result in you receiving hereditary or germline results separate and apart from information about your cancer. If you have any questions or need additional information, please consult your doctor before signing.

Purpose & Process

Tempus will perform Next Generation Sequencing ("NGS") and analysis of certain regions of your DNA (and for the xT Test, your RNA) that may be associated with your cancer. In addition, if your doctor has ordered the xG Test, GeneDx, a laboratory with whom Tempus has contracted, will perform hereditary genetic testing based on a blood sample. Tempus will report Test results to your doctor. The goal of the Tests is to identify key characteristics of your cancer that may inform clinical decision making. Tempus will work with your doctor to obtain tumor samples, normal samples (saliva or blood), and information from your electronic health record. Genetic material, including DNA (and for the xT Test, RNA), will be obtained from samples, stored, and analyzed. Tempus will compare DNA sequencing results obtained from the tumor cells with those obtained from your normal cells. In order to improve the quality of our testing, Tempus may retain your tissue, cells and/or DNA or RNA extracted from your cells for an indefinite period of time following the testing ordered by your doctor. Tempus may use leftover materials for internal purposes, including quality assurance and test validation. Tempus may also remove personally identifying information from these materials in accordance with applicable law and use it for de-identified research purposes, including future research related to cancer diagnosis, testing, and therapies.

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.

Risks, Benefits, & Limitations

The Test reports do not provide any medical diagnosis and do not make any specific treatment recommendations; instead they provide information for your doctor to review. There is no guarantee that performance of a 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 a specific type of cancer, certain clinical trials may be available to you, or genetic information may impact your ongoing healthcare 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 technology also may not identify all variants related to you or your cancer, because there is a possibility of testing errors 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 Tests after those results have been made available to your doctor through the test reports described above.

Assignment of Insurance Benefits; Authorization; Appointment as Legal Representative

By signing below, you hereby assign all applicable health insurance benefits and/or insurance reimbursement you have under your health plan(s) to Tempus Labs, Inc. ("Tempus") for services performed by Tempus. You also appoint Tempus as your 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 of your rights in connection with any claim, right, or cause of action including litigation against your health plan that you may have, including, the right to claim on your behalf, all such benefits, claims, or reimbursement, and to seek any other applicable remedy, including fines.

Specimen Release

By signing below, you authorize the release of your original pathology slides/blocks/clinical specimens and other materials, including extracted DNA and RNA, that are requested by Tempus ("Materials"), and hereby direct the pathology lab receiving this request to release and provide all such Materials to Tempus. 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 you may have for any such loss or damage to the Materials.

CONSENT TO TEST

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

Last updated October 04, 2021. The most recent Tempus requisition can be found at Tempus.com/resources.