# TEMPUS xE WHOLE EXOME REQUISITION FORM — 2023.06.05

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 |
|---|---|---|
| | | |

## C. TESTING OPTIONS

| Common test combinations | Test descriptions | Specimen required | Optional add-on tests (select all that apply): |
|---|---|---|---|
| ☐ **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 | **FFPE Tissue**<br>☐ PD-L1 IHC:<br>☐ 22C3 **DEFAULT**<br>☐ 28-8<br>☐ SP142<br>☐ SP263<br>☐ MMR IHC |
| **Individual test options** | | | |
| ☐ **xR (RNA Only) — Solid Tumor Only** | Whole transcriptome RNA sequencing test. | FFPE Tissue | |
| ☐ **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**

☐ Mobile phlebotomy ☐ Sample previously submitted

Date of Collection:

☐ **Saliva**

☐ 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 ☐ II ☐ III ☐ IV ☐ Other:

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.
☐ Copy of insurance card.

## F. BILLING INFORMATION

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

| Patient Relationship to Policy Holder | Bill Type: | Patient Status (for Medicare patients) |
|---|---|---|
| ☐ Self ☐ Spouse ☐ Child ☐ Other: | ☐ Insurance ☐ Hospital/Institution ☐ Self pay/International | ☐ 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) |
|---|---|
| | |