Personalis®

NeXT Dx Test
REQUISITION FORM

FAX: 1 (650) 752-1350
EMAIL: clinical@personalis.com

Patient Information

FIRST NAME	LAST NAME		MI
STREET ADDRESS	CITY	STATE	ZIP
RACE/ETHNICITY	DATE OF BIRTH (mm/dd/yyyy)	PRIMARY PHONE NUMBER	SEX M ◯ F ◯
EMAIL			
MEDICAL RECORD NUMBER (MRN)	**STUDY PATIENT ID** (if applicable)		

OFFICE USE ONLY

Ordering Provider

HOSPITAL/INSTITUTION		ACCOUNT NO
ORDERING PROVIDER (full legal name)		
STREET ADDRESS		
CITY	STATE	ZIP
NPI#		PHONE
EMAIL (required for report delivery)		FAX

☐ Send Copy (please check box for additional copy of report)

NAME	INSTITUTION
PHONE	EMAIL

Please Attach the Following

- ☐ Copy of recent pathology and/or cytology reports
- ☐ Test results from all other Molecular Diagnostic Tests
- ☐ Clinical notes and/or progress notes

Test Selection

- ☐ Personalis NeXT Dx™ Test

Payment (select one)

◯ **BILL PATIENT INSURANCE** (Please attach a copy of the patient's Face Sheet and/or insurance information)

◯ MEDICARE ◯ MEDICARE ADVANTAGE ◯ OTHER HEALTH INSURANCE

PLAN NAME

POLICY HOLDER NAME	POLICY HOLDER DOB (mm/dd/yyyy)
POLICY #	GROUP #
PRIOR AUTHORIZATION #	☐ ABN ATTACHED

PATIENT STATUS (required for Medicare patients)

◯ OFFICE (Non-hospital) ◯ OUTPATIENT ◯ INPATIENT (Not yet discharged)

◯ INPATIENT (discharge date required - mm/dd/yyyy)

◯ **BILL PATIENT SELF PAY**

NAME

PHONE | EMAIL

◯ **BILL FACILITY** (Hospital/Institution)

NAME

PHONE | EMAIL

◯ **PHARMA/BIOTECH**

STUDY SPONSOR | CLINICAL TRIAL #

Pathology Information ☐ (please check box to send additional copy of report to the Pathologist listed below)

HOSPITAL / INSTITUTION NAME	SUBMITTING PATHOLOGIST NAME	
EMAIL	PHONE	FAX

Specimen Information (please note that heme samples are not accepted specimen types at this time)

Choose one: ◯ SPECIFIC SPECIMEN REQUESTED ◯ PATHOLOGIST CHOOSES SPECIMEN	SPECIMEN ID		COLLECTION DATE (mm/dd/yyyy)
	FFPE TISSUE ◯ I will arrange specimen shipment ◯ Contact pathology lab to obtain specimen		SPECIMEN TYPE ◯ **FFPE*** Tumor content (%) _____
DIAGNOSIS (e.g. Adenocarcinoma)	STAGE	PRIMARY TUMOR SITE (original cancer site if metastasis, e.g. lung)	* FFPE: tumor block, unstained slides, curls (accompanying H&E slide required with curls); ≥ 20% tumor content
DATE OF DIAGNOSIS (mm/dd/yyyy)	ICD-10 Primary Diagnosis Codes _____		
SPECIMEN BIOPSY SITE ☐ Primary ☐ Metastasis ☐ Recurrence ☐ Refractory ☐ Relapse	HISTOLOGY		

TARGETED THERAPIES _____ IMMUNOTHERAPIES _____

Certificate of Medical Necessity/Consent/Test Authorization and Provider Signature

My signature constitutes a Certificate of Medical Necessity and certifies that I am the patient's health care provider. I have explained to the patient the nature and purpose of the testing to be performed, discussed the risks and benefits of the testing, and offered alternatives to such testing. I have obtained informed consent, to the extent legally required, to permit Personalis, Inc. to (a) perform the testing specified herein, (b) retain the remaining materials such as DNA and RNA, test results and associated data (including whole-exome and transcriptome analysis data) for an indefinite period for internal quality assurance and/or operations purposes, and (c) de-identify the test results and associated data (including whole-exome and transcriptome analysis data) and use or disclose such information for future unspecified research or other purposes and (d) release the test results to the patient's third-party payer as needed for reimbursement purposes.

PROVIDER SIGNATURE DATE (mm/dd/yyyy)