ONCOLOGY REQUISITION

1 Commercial Street, Branford, CT 06405
Tel: **833-486-6260** / Fax: 516-953-8154
Tax ID# 13-6171197 / CLIA# 07D2101517
CT Lic#: CL-0830 / CAP #9283362

Please place green collection kit barcode here.
123456-2-X

Please be sure to fill out all highlighted fields. Failure to fill them in may result in delayed testing and delivery of results.

PATIENT INFORMATION

Sema4 will use this information to contact the patient via automatic email, SMS, and/or phone regarding payment, testing status, and online results access. By submitting this requisition, I confirm that I have obtained the patient's authorization to be contacted by Sema4 by these means (email address must be specific to patient listed on form).

PATIENT EMAIL ADDRESS	PATIENT MOBILE/PRIMARY NUMBER
RECOMMENDED	REQUIRED
LAST NAME REQUIRED	**FIRST NAME** REQUIRED MI
DATE OF BIRTH MM / DD / YYYY	**BIOLOGICAL GENDER** ☐ M ☐ F REQUIRED

CLIENT MRN

ADDRESS REQUIRED **CITY / STATE / ZIP**

Ethnicity *(Check all that apply)*

☐ African American ☐ Ashkenazi Jewish ☐ Asian ☐ Caucasian ☐ Hispanic
☐ Middle Eastern ☐ Native American ☐ Pacific Islander ☐ Other ☐ Unknown

BILLING INFORMATION

Bill to: ☐ Hospital/Inpatient (Discharge date:_____) ☐ Insurance below/Outpatient ☐ Self-pay

POLICYHOLDER LAST NAME	POLICYHOLDER FIRST NAME	POLICYHOLDER DOB
REQUIRED	REQUIRED	MM / DD / YYYY
INSURANCE CARRIER	**INSURANCE ID**	**GROUP NO.**

BILLING ADDRESS

SECONDARY INSURANCE ☐ YES ☐ NO

SECONDARY INSURANCE NAME	GROUP NO.

LABORATORY TEST ORDERED

Test Selection (Required)

☐ **Solid Tumor Panel (161 genes) plus Microsatellite Instability Analysis**
Please note: this test can only be ordered if a normal specimen is also provided.

☐ **Solid Tumor Panel Only (161 genes)**

☐ **Microsatellite Instability (MSI) Analysis Only**
Please note: this test can only be ordered if a normal specimen is also provided.

☐ **Sema4 Signal WES/WTS (includes MSI and TMB)***
Please note: this test can only be ordered if a normal specimen is also provided.

☐ For solid tumor samples only: If the specimen provided is insufficient to complete the Sema4 Signal WES/WTS test, check this box to automatically proceed with Sema4 Solid Tumor Panel plus Microsatellite Instability Analysis

Reporting of incidental/secondary germline findings
Please note: By default, this test will report identified germline secondary findings.

☐ Check to **exclude cancer** related secondary findings (including and in addition to those outlined by the ACMG) from this patient's test report

☐ Check to **exclude non-cancer** related secondary findings outlined by the ACMG from this patient's test report

☐ **Sema4 Signal PanCancer (2,197 genes) includes MSI and TMB***
Please note: this test can only be ordered if a normal specimen is also provided.

☐ For solid tumor samples only: If the specimen provided is insufficient to complete the Sema4 Signal PanCancer test, check this box to automatically proceed with Sema4 Solid Tumor Panel plus Microsatellite Instability Analysis

Reporting of incidental/secondary germline findings
Please note: By default, this test will report identified germline secondary findings.

☐ Check to **exclude cancer** related secondary findings (including and in addition to those outlined by the ACMG) from this patient's test report

** Tumor Mutation Burden is provided for samples with >20% tumor percentage*

REFERRING PROVIDER INFORMATION

Name REQUIRED	Genetic Counselor / Additional Clinician
NPI#	Clinic / Institution REQUIRED
Address REQUIRED	Telephone
	Fax
Sending Physician Practice: ☐ Doctor's Office ☐ Referral Lab	☐ Hospital - Inpatient ☐ Hospital - Outpatient

MEDICAL PROVIDER SIGNATURE OF CONSENT REQUIRED BELOW: I certify the patient specified above and/or their legal guardian has been informed of the benefits, risks, and limitations of the test(s) requested. I have answered this person's questions. I have obtained informed consent from the patient or their legal guardian for this testing, to the extent required by law.

SIGNATURE **DATE** MM / DD / YYYY

CLINICAL INDICATIONS/PATHOLOGY

Type of Cancer	Stage of Cancer

Tumor Specimen Information ***(Include any pathology reports)***

Collection Date: MM / DD / YYYY Collection Time: _____ : _____ ☐ AM ☐ PM
Collected By: _____
# of Specimens sent: Lavender (EDTA) _____ Paraffin Block* _____
Unstained Slides and H&E Stained* _____ gDNA/RNA _____
*Anatomic site/Collection Method: _____
Fresh Frozen, please contact lab for transportation arrangements.
☐ Sema4 to procure the tumor specimen
Pathology Department Name: _____
Pathology Department Phone Number: _____

Tumor BLOCK ID _____ **Client ID** _____

Normal Specimen Information

Collection Date: MM / DD / YYYY Collection Time: _____ : _____ ☐ AM ☐ PM
Collected By: _____
# of Specimens sent: Lavender (EDTA) _____ Paraffin Block* _____ Buccal Swab _____
Unstained Slides and H&E Stained* _____ gDNA/RNA _____ Saliva _____
*Anatomic site/Collection Method: _____
Fresh Frozen, please contact lab for transportation arrangements.

Normal BLOCK ID _____

The tumor and/or normal specimen was collected from the patient in New York State: ☐ Yes ☐ No

PATIENT HISTORY

ICD Dx CODE(S) *The ICD-10-CM codes listed here are for reference only; practitioners should select ICD-10-CM code(s) based on the patient's condition as of the date of service, even if such code(s) are not listed below.*

☐ C71.9 Malignant neoplasm of brain, unspecified
☐ C18.9 Malignant neoplasm of colon, unspecified
☐ C54.1 Malignant neoplasm of endometrium
☐ C61 Malignant neoplasm of prostate
☐ C43.9 Malignant melanoma of skin, unspecified
☐ C73 Malignant neoplasm of thyroid gland
☐ C34.90 Malignant neoplasm of unspecified part of unspecified bronchus or lung
☐ C50.919 Malignant neoplasm of unspecified site of unspecified female breast
☐ C80.1 Malignant (primary) neoplasm, unspecified
☐ Other: _____

Patient Testing History
☐ No prior molecular testing ☐ Patient has had prior molecular testing *(attach results)*
Age of primary cancer diagnosis: _____

Family History of Cancer
☐ None ☐ Yes *(complete below)*

Relation to patient	H/o cancer	Dx age
☐ Maternal ☐ Paternal ☐ Other		
☐ Maternal ☐ Paternal ☐ Other		

Add-on option with FFPE tissue
*Please note: If sending slides, an additional 1 H&E and 2 unstained (PD-L1) or 6 unstained (MMR) **4 microns** thick slides are required. Slides must be positively charged, air-dried, and labeled "IHC".*

☐ PD-L1 by IHC
☐ 22C3 clone for pembrolizumab (performed by default)
or
☐ SP142 clone for atezolizumab
☐ DNA Mismatch Repair (MMR) Proteins by IHC

For more information about technical details and genes analyzed, please visit:
https://sema4.com/oncology

COMPLETE AND SUBMIT ALL PAGES TO LABORATORY

Consent for Sema4 Signal Whole Exome/Transcriptome, and PanCancer Profiling

I, _____,

hereby request genetic testing for

☐ Myself

☐ My child _____

I have received verbal and written information (please see sema4.com/testcatalog for test-specific information sheet) from my physician or from a genetic counselor that described, in words that I understood, the nature of the genetic testing that I/my child am about to undergo in connection with this consent, as well as the accuracy, risks and limitations of the test(s). I am aware that I may speak to my provider or call Sema4 at 1-800-298-6470 option 2 with any questions about this test.

I understand that my/my child's specimen(s), such as a small sample from the tumor, and blood, saliva, or other non-tumor tissue, will be used for this testing. I understand that no test will be performed on my sample other than the one(s) authorized by me and my healthcare provider. I have reviewed the test order made in connection with this consent, and I hereby give consent to have my specimen tested as set forth in the order.

Test Purpose:

I understand that the specimen(s) will be analyzed for changes in my/my child's tumor DNA and RNA that may impact the diagnosis, prognosis, likelihood of responding to certain treatments, and/or opportunity to participate in some clinical trials. It is possible that the test results will not identify any changes that could influence my/my child's care.

Limitations:

- I understand that this test is designed to analyze genes/genetic changes that may be clinically informative. The results from this test are provided to my/my child's doctor to aid them in medical management.
- This test does not analyze every gene or genetic change within my/my child's cancer or normal (also called germline) genetic material. This test may not be able to detect certain genetic changes due to technical limitations.
- I understand that although the likelihood of an incorrect diagnosis or a misinterpretation of the result is small, infrequent errors may occur.
- There may be genetic changes of unknown clinical significance found in the tumor portion of this test. While these findings may not currently provide clinically relevant information, they will still be reported if identified in the tumor and not in the germline.
- As the cancer's genetic makeup may evolve over time, genetic or other types of testing may need to be performed on other samples during the course of my/ my child's treatment and follow up.
- Only clinical trials in the United States for which I may be eligible will be reported.
- The quality and quantity of the specimen received may impact the test results.

Secondary/Incidental findings:

It is possible that genetic changes in my/my child's non-tumor sample will be identified. These inherited germline findings are considered "secondary" (or incidental) genetic information that is not directly related to the reason that my doctor ordered this test, but that may affect my health and the health of my child and family members. They include harmful changes in genes that are associated with cancer predisposition as well as results pertaining to those listed in the ACMG Recommendations for Reporting of Secondary Findings in Clinical Exome and Genome Sequencing (ACMG SF v2.0) (PMID: 27854360, http://www.acmg.net/ACMG/Advocacy/Policy-Statements/ACMG/Advocacy/Policy-Statements.aspx). The findings outlined by the ACMG are genetic changes in genes strongly associated with diseases where some preventative measures and treatment options exist. Examples include: cancer predisposition and non-cancer related conditions such as cardiomyopathies, connective tissue disorders, and familial hypercholesterolemia. In the case that a germline finding is reported, a consult with a medical provider, clinical genetics professional (such as a genetic counselor) and/or confirmatory germline genetic testing may be appropriate follow-up options.

The inclusion of secondary findings in my test report will be indicated on the test order placed by my healthcare provider. I have the right to change my order, and if I wish to do so I will contact my/my child's healthcare provider to discuss the available options, but I understand that any change request or consent withdrawal will not affect results that have already been reported.

I will discuss any appropriate medical intervention with my healthcare provider before taking any action based on my/my child's results. I understand that additional genetic testing may be necessary. Even though some inherited genetic changes may be detected by this test, if there is an inherited condition that is suspected in me/my child or in my family, a different test with the purpose of examining germline genetic changes based on family and/or personal history may be recommended by my/my child's physician.

GINA

There are some federal and state laws that address genetic discrimination. The US Genetic Information Nondiscrimination Act (GINA) may prohibit discrimination by employers and health insurances. This law, however, does not protect people in the military nor possible discrimination by other types of insurance such as life, disability or long-term care.

Sample storage for future clinical purposes

Sema4 may securely store a portion of my/my child's sample indefinitely for the sole purpose of performing future clinical testing that I authorize and consent to. My sample will not be used for any other purpose without my consent, and no test will be performed on my sample other than the one(s) authorized by me and my healthcare provider.

If I do not want to have any of my/my child's sample stored for future clinical testing that I request, I may initial here_____, and my/my child's sample will be destroyed at the end of the testing process or not more than 60 days after collection. I may withdraw this consent by contacting Sema4, including by emailing privacy@sema4.com.

De-identified research

Sema4 may de-identify and use all data and information generated and received in connection with this test to support medical and academic research relating to health, disease prevention, drug development, and other scientific purposes, and I will receive no compensation in connection with such research. Data and information are "de-identified" by removing any information that could be used to identify a specific person, such as a name, email address, or date of birth. Sema4 may also give the deidentified data and information to its research partners and may submit it to research databases for use in scientific and medical research, including scientific databases that are maintained by the federal government, such as a database kept by the National Institutes of Health ("NIH"), an agency of the federal government that funds research. Researchers have to apply to the NIH to see the information in the database.

If I do not want to have any of my/my child's de-identified data and information used in research consistent with this consent, I may initial here_____, or request this by contacting Sema4, including by emailing privacy@sema4.com.

Permission to contact

I understand that Sema4 may wish to contact me/my child in the future, including for the following reasons: research purposes, the provision of general information about research findings, and/or the provision of information about the results of tests on my/my child's sample(s). I understand that I may notify Sema4 to opt out of such future contact, including by emailing privacy@sema4.com.

The results of my/or my child's test will be explained to me by a genetic counselor or by my physician who will have the opportunity to discuss my results with a geneticist. I have had the opportunity to have all of my questions answered. If I am signing this form on behalf of a minor for whom I am the legal guardian, I am satisfied that I have received enough information to sign on his or her behalf.

I understand that this consent is being obtained in order to protect my right to have all of my questions answered before testing. I understand that the results of this testing will become part of my medical record and may only be disclosed to individuals who have legal access to this record or to individuals who I designate to receive this information.

_____ _____

Signature of person being tested (or guardian) Date