# DETERMA Rx + EGFR

# Test Requisition Form

www.oncocyte.com
Customer Service:
**PHONE/FAX** 1.844.ONCOCYTE (1.844.662.6298)
**FAX** 1-800-406-5189
**EMAIL** customer.service@oncocyte.com

Order ID

For Oncocyte Use Only

## Ordering Physician or Delegate to Complete

### Test Selected

◉ DetermaRx™ ◉ EGFR (tumor tissue analysis - Exon 18-21)

**DetermaRx Intended Use:** Improving the quality of post-surgical treatment decisions by identifying patients at highest risk of 5-year mortality, and therefore the most likely to benefit from adjuvant chemotherapy, in stage IA, IB and IIA (8th edition) non-squamous non-small cell lung cancer patients whose tumors have been fully resected and are candidates for chemotherapy.

### Ordering Physician Information

Physician Name _____

Organization Name _____

NPI Number _____

Street Address _____

City _____ State _____

Postal Code _____ Country _____

Phone _____ Fax _____

Email Address (For online report access) _____

Report Delivery ◉ Encrypted Email ◉ Secured Fax

You are authorizing the electronic delivery of test results by Oncocyte in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and the rules reflected in the HITECH Act.

### Patient Information

Last Name _____ Suffix _____

First Name _____ Middle Initial _____

Sex ◯F ◯M ◯Undisclosed Date of Birth (DOB mm/dd/yyyy) _____

Last 4-digits of SSN _____ Medical Record # _____

Street Address _____

City _____ State _____

Postal Code _____ Country _____

Phone _____

Email Address (For Invoicing) _____

Patient Diagnosis (ICD-10 Codes) _____

Hospital Status at Time of Specimen Collection:

◯ In-Office Procedure ◯ Hospital Outpatient ◯ Hospital Inpatient (>24 hour)

Discharge Date (mm/dd/yyyy) _____ ◯ Not Yet Discharged

### Pathology Laboratory Information

◯ Oncocyte to request specimen from Pathology ◯ Ordering Physician to request specimen from Pathology

Contact Name _____

Organization Name _____

Street Address _____

City _____ State _____

Postal Code _____ Country _____

Phone _____ Fax _____

### Ordering Physician Signatures & Attestations

I, the undersigned*, attest that I ordered the DetermaRx test and/or the EGFR test for my eligible patient, and this order is appropriately documented in the Patient Medical record. The test(s) is/are medically necessary and reasonable to provide information to allow me to personalize treatment for my patient's medical condition. This patient has a non-squamous NSCLC with a tumor size < 5cm, and there are no positive lymph nodes (i.e. American Joint Committee on Cancer Eighth Edition Stages I and IIA); the patient is sufficiently healthy to tolerate chemotherapy, and adjuvant platinum containing chemotherapy is being considered for the patient. I have provided Oncocyte with my patient's current insurance information, and I understand that Oncocyte will be billing the patient's insurance company and accepting assignment on this claim. The patient and/or their legal guardian has been informed of the benefits, risks, and limitations of the laboratory test(s) and requested and consented for this test to be performed.

X _____ _____

Treating Physician Signature (or Authorized Delegate) Date (mm/dd/yyyy)

*Delegate has the authorization to sign supporting forms and documents on behalf of the Treating Physician for Oncocyte orders.

### Billing Information

Billing Type: ◯ Medicare ◯ Medicaid/IPA ◯ Commercial ◯ Self-Pay

**Primary Insurance Name** _____

Plan Name _____

Insurance ID# _____ Group# _____

Patient relationship with subscriber ◯ Self ◯ Spouse ◯ Dependent

Subscriber Name (if not patient) _____

Address _____

Sex ◯F ◯M ◯Undisclosed Date of Birth (DOB mm/dd/yyyy) _____

**Secondary Insurance Name** _____

Plan Name _____

Insurance ID# _____ Group# _____

Patient relationship with subscriber ◯ Self ◯ Spouse ◯ Dependent

Subscriber Name (if not patient) _____

Address _____

Sex ◯F ◯M ◯Undisclosed Date of Birth (DOB mm/dd/yyyy) _____

**Attach a copy of both sides of primary/secondary insurance cards.**

If Patient needs financial assistance, call 1.844.662.6298 or visit Oncocyte.com to obtain the Financial Assistance Form.

### Specimen Information

IASLC TNM Staging (when available) T _____ N _____ M _____

IASLC Overall Stage (select one) ◯ IA ◯ IB ◯ IIA

FFPE Block ID (Case ID) _____

Specimen Collection Date (mm/dd/yyyy) _____

Number of primary non-squamous NSCLC lesions to be tested _____

## Pathology to Complete

Review and update your contact information above and fill in the sample information. Select a surgical FFPE specimen (not a biopsy) with a tumor area greater than 25% of the block's total tissue area, without regard to cell density. The FFPE specimen must be non-squamous NSCLC in a stage IA, IB, or IIA.

Specimen Type Submitted*

◯ Block ◯ Please return specimen to the above address if submitting block

◯ Slides # of slides sent

*Oncocyte makes every effort to preserve and not exhaust tissue, but in small and thin specimens, there is a possibility of exhausting the specimen in order to ensure adequate material and reliable results.

FFPE Block(s) Cross-Section ID (Case Affix) _____

Date Block(s) Removed from Storage: (mm/dd/yyyy) _____

Completed by X _____

Date (mm/dd/yyyy) _____

**DetermaRx testing performed by Oncocyte Corporation,** 15 Cushing, Irvine, CA, 92618

**EGFR testing performed by Cellnetix** 12501 E. Marginal Way S., Suite 200 | Tukwila, WA 98168

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