Variantyx

**OncoAlly™**
**Solid Tumor Analysis**
Test Requisition Form
Page 1 of 2

| | |
|---|---|
| Patient Name | |
| Date of Birth | |

Affix barcode label of Patient's sample here

**Required Information Checklist:**

- ❑ Patient demographics
- ❑ ICD-10 codes
- ❑ Healthcare provider signature
- ❑ Signed informed consents
- ❑ Clinical information, pathology report and previous genetic reports
- ❑ Completed TRF and all clinical notes faxed to 508-302-8022

## OncoAlly™ Solid Tumor Analysis by Variantyx

| | |
|---|---|
| ◯ OncoAlly™ Solid Tumor Analysis (OA001) | Provides an oncology treatment optimization and therapy association analysis based on comprehensive molecular profiling of tumor and normal tissue. The test includes DNA sequence analysis (single nucleotide variants, deletions/insertions), duplication/deletions, copy number variants (CNVs), onco-pharmacogenomic variants, microsatellite instability status, HPV integration, tumor mutational burden, and RNA analysis, which detects gene fusions and complex rearrangements. |
| Opt in for PD-L1, *please select one*:<br>◯ PD-L1 22C3, FDA (KEYTRUDA®) ◯ PD-L1 SP263, FDA (IMFINZI®)<br>◯ PD-L1 28-8, FDA (OPDIVO®) ◯ PD-L1 SP142, FDA (TECENTRIQ®) | Provides combined positive score (CPS) / tumor proportion score (TPS) |
| ◯ Opt in for OncoAlly™ Cancer predisposition (OA010) | Provides sequence analysis (single nucleotide variants, deletions/ insertions, characterized intronic variants) and copy number variants analysis (duplications/deletions, mobile element insertions and inversions) of 87 genes associated with hereditary cancer. |
| ◯ Opt in for Genomic Unity® Pharmacogenomics Analysis (PG001) | Provides analysis of common variants associated with drug metabolism and pharmacogenetics response. The test includes sequence analysis and copy number variants analysis of known star alleles in 13 genes that were recommended by the FDA for predicted adverse drug reactions and drug response. |

## Ordering Healthcare Provider

| | | | |
|---|---|---|---|
| First Name | Last Name | | NPI # |
| Facility Name | | | Phone |
| Facility Address | | | Fax |
| City | State | Zip Code | Email |

## Additional Report Recipients

| | | | |
|---|---|---|---|
| Name | Phone | Fax | Email |
| Name | Phone | Fax | Email |

## Patient Information

| | | | | |
|---|---|---|---|---|
| First Name | Last Name | MI | DOB | Genetic Sex ◯ Male ◯ Female ◯ Other _____ |
| Address | | ID / MR# | | Gender identification (optional): |
| City | State | Zip Code | Phone | Email |
| Other Name (if different than listed above): ◯ Please use this name in communications. | Pronouns | Preferred language ◯ English ◯ Spanish | | |

## Patient Medical History

| | | |
|---|---|---|
| ICD-10 | Primary cancer diagnosis | Stage |

| | | | |
|---|---|---|---|
| Radiation ◯ Yes ◯ No | Surgery Y / N<br>Date: | PD-L1 status ◯ Negative ◯ >1% ◯ >10% ◯ >50%<br>**If already performed please provide a copy of the report with this test requisition form.* | Metastatic ◯ Yes ◯ No |

Lines of therapy ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

**If 1-5 selected, please indicate the name of the therapies administered.*

Lines of therapy metastatic ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

**If 1-5 selected, please indicate the name of the therapies administered.*

| | | |
|---|---|---|
| Targeted therapy **(provide the drug name)* | Chemotherapy **(provide the drug name)* | Immunotherapy **(provide the drug name)* |

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## Patient Medical History

For Gastric/ GEJ cancer - required: Her2 (ERBB2) status
FISH: ◯ Positive ◯ Negative IHC: ◯0 ◯1 ◯2 ◯3

Optional: Other information, Previous history of transplant

For Breast cancer: Her2 (ERBB2) status
FISH: ◯ Positive ◯ Negative ◯ N/A IHC: ◯0 ◯1 ◯2 ◯3

Estrogen receptor ◯ ER+ ◯ ER-

Progesterone receptor ◯ PR+ ◯ PR-

For Endometrial cancer:

Estrogen receptor ◯ ER+ ◯ ER-

Progesterone receptor ◯ PR+ ◯ PR-

## Tumor specimen information

| Specimen Type ◯ Primary tumor ◯ Metastatic | Tumor Tissue: | Date of resection/biopsy | Additional fixative use: |
|---|---|---|---|
| | | | |

## Normal Specimen Information

| Sample Type ◯ Blood | Sample Will Be Collected ◯ In-clinic ◯ By Variantyx ◯ Patient given kit | Collection date | Please check if your patient has had a: ◯Blood transfusion within the last two weeks ◯Bone marrow transplant |
|---|---|---|---|
| | | | |

## Specimen Retrieval

Please send: ◯ 10-20 unstained slides + one H&E slide ◯ *If PD-L1 is opted-in, please send additional 5 unstained slides*

| Pathology Lab name: | Address: | Phone: |
|---|---|---|
| | | Fax: |
| Sample accession number: | | Email: |
| Pathologist Name: | MRN: | Surgical number: |
| Biopsy site: | | Date of Specimen retrieval: |

## Billing Information

◯ Insurance Billing

| Insurance Company | Policy # | Group # |
|---|---|---|
| | | |

| Policy Holder First Name | Policy Holder Last Name | Policy Holder DOB |
|---|---|---|
| | | |

| Policy Holder Address | Who is the Policy Holder? ◯ Patient ◯ Spouse ◯ Parent |
|---|---|
| | |

| Employer's Address | Patient status at time of sample collection: ◯ Office (non-hospital) ◯ Outpatient ◯ Inpatient (requires discharge date below) *or* ◯ Not yet discharged _____ |
|---|---|
| | |

◯ Institutional Billing

An invoice will be sent to the institution listed above. Please contact us for alternate billing.

◯ Patient Payment

*Who should be contacted for billing purposes? An invoice will be sent to the patient email provided. Insurance will not be billed.*

Payer Name: Payer Phone: Payer Email:

## Healthcare Provider's Statement

By my signature below, I indicate that I am the referring physician or authorized healthcare provider. My signature below certifies the medical necessity for the test and that the results of this test will inform the patient's ongoing treatment plan. I have explained the purpose of the test described above and obtained from the patient an informed consent, meeting the requirements of applicable law, for Variantyx or any laboratory Variantyx has contracted with, to (a) perform the test(s) described in this form; (b) obtain, receive, and release, test results and any corresponding medical information to the patient third party payer as necessary for reimbursement purposes; (c) retain test results, tissue, and information obtained from the patient, 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.

Healthcare provider signature _____ Date _____

**Address**: 1671 Worcester Rd, Suite 300 Framingham, MA 01701 | **Phone**: 617-209-2090 | **Fax**: 1-508-302-8022| **Email**: info@variantyx.com
**Website**: www.variantyx.com | **Document number:** VYX-406-0523