Test Requisition Form

Order ID

For Razor Genomics Use Only

Customer Service
Phone/Fax 1-844-662-6298
Fax 1-800-406-5189
Email cs@razorgenomics.com

Ordering Physician or Delegate to Complete

Test Selected

◯ RiskReveal™

RiskReveal 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: ◯ Secured Fax ◯ Online Portal

You are authorizing the electronic delivery of test results by Razor Genomics, Inc.™ in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and the rules reflected in the HITCH Act.

Patient Information

Last Name _____ Suffix _____

First Name _____ Middle Initial _____

Sex: ◯ M ◯ F ◯ 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

◯ Razor Genomics, Inc. 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 RiskReveal 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 Razor Genomics, Inc. with my patient's current insurance information, and I understand that Razor Genomics, Inc. 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 Razor Genomics, Inc. 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: ◯ M ◯ F ◯ 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: ◯ M ◯ F ◯ 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 www.razorgenomics.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 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

◯ Slides # of slides sent

◯ Please return specimen to the below address if submitting block

*Razor Genomics, Inc. 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) _____

RiskReveal testing performed by Razor Genomics, Inc. 111 10th Avenue South, Suite 102, Room 123 | Nashville, Davidson County, Tennessee 37203

RAZORGENOMICS™ Transforming Cancer Care