CANCERPLEX
GENOMIC TEST REQUISITION FORM

KEW, Inc. | 840 Memorial Drive, 4th Floor | Cambridge, MA 02139
P: 617.945.7922 | F: 857.242.3949 | CLIA #: 22D2060722
Please complete and fax to KEW Customer Care: **857-242-3049**

ORDER DATE* _____ **indicates a required field*

PATIENT

Last Name*	First Name*	MI

Medical Record #*	Date of Birth*	Gender* ☐ Male ☐ Female

Street Address*	Apt. #

City*	State*	ZIP Code*

Phone Number*	Ethnicity*

PATIENT INSURANCE *Please attach a front & back copy of patient's insurance card*

Billing Type*
☐ Private Insurance ☐ Medicare ☐ Self-Pay

Primary Insurance

Policy #	Group #

Insured Name

Insured Date of Birth	Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status*
☐ Hospital Inpatient ☐ Hospital Outpatient ☐ Non-hospital Patient

Institution*	Discharge Date*

DIAGNOSIS

Diagnosis*	Stage

Primary Tumor Site* (e.g., Lung, Colon, Breast)	ICD-10 Codes Listed*

ORDERING PHYSICIAN

Ordering Physician*	NPI #*

Practice/Institution*

Street Address*

City*	State*	ZIP Code*

Primary Office Contact	Email Address*

Phone Number*	Fax Number*

SEND DUPLICATE REPORT TO

Healthcare Provider

Phone Number	Fax Number

TESTS ORDERED *Please see reverse side for details on each CANCERPLEX® product*

☐ **CANCERPLEX® FP** (Full Panel; includes MSI, TMB and viral)

☐ **CANCERPLEX® TX** (FDA-approved targeted therapies; includes MSI, TMB and viral)
- ☐ Reflex to CANCERPLEX® FP if negative

☐ **CANCERPLEX® TS** (Tumor Specific; includes MSI, TMB and viral)
- ☐ GYN & Breast (includes BRCA & DNA Repair)
- ☐ GU (includes DNA Repair)
- ☐ GI
- ☐ Lung
- ☐ Melanoma & Skin
- ☐ Head & Neck
- ☐ Reflex to CANCERPLEX® FP if results are not actionable

☐ **PD-L1 IHC** (add-on test)

I certify that the requested test is medically neceessary and that I have obtained informed consent to permit KEW Inc. to (a) perform the specified testing, (b) de-identify the test results and use or disclose such de-identified results for future unspecified research or other purposes, and (c) release the test results to the patient's third-party payor for reimbursement purposes.

X _____ _____
Ordering Physician's Signature* Date*

TO BE COMPLETED BY THE PATHOLOGIST

PATHOLOGIST*

Hospital/Institution*

Submitting Pathologist*

Phone Number*	Fax Number*

Email Address

SPECIMEN* *Please attach a copy of the pathology report*

Specimen Site* _____ ☐ Primary ☐ Metastatic	Specimen ID*	Date of Procedure*

I have inspected the specimen and found that:
- ☐ at least 50% of the cells are tumor
- ☐ less than 50% of the cells are tumor (tissue will be macrodissected at KEW Lab)

☐ I give KEW permission to exhaust the specimen	Date Removed from Storage*

TERMS FOR ORDER FORM

KEW Inc. ("KEW") will perform the laboratory test described on the reverse side of this order form (the "Services") subject to the following terms and conditions:

1. **Payment.** If private insurance or Medicare is selected as the billing type, a copy of the front and back of the primary and secondary insurance cards must be included, and KEW will bill the applicable third-party payer for the cost of the Services. If Self-Pay is selected, KEW's third party billing vendor will contact the patient directly.

2. **Limitation of Results.** KEW does not guarantee that the Services will be error free. KEW makes no representations or warranties as to the Services. The test results provided by KEW in connection with the Services are provided for informational purposes only and are not intended to be a substitute for a physician's professional judgment and consultation. There are various features of cancer that cannot be uncovered by these tests alone. False positive and false negative test results are possible due to heterogeneity of the tumor, technical aspects of the test, and other factors. Potential therapies can change and references to approved therapies should not be considered final or comprehensive. Testing by KEW only constitutes a partial evaluation of a subject's state of health and does not represent a diagnosis or treatment of disease. The information provided by KEW about test results may be incomplete.

3. **Signature.** The order form must be signed by the ordering physician. The ordering physician shall be solely responsible for confirming that a legally-effective informed consent has been obtained from the patient or his/her authorized representative as required by applicable law. By ordering a test from KEW, the ordering physician certifies that this consent is in place, and the test results will be used and disclosed only in accordance with applicable law.

4. **Specimen Retrieval.** The ordering physician and pathologist will ensure (i) that all tissue samples and other patient information provided to KEW are correctly identified, accurate, and complete and (ii) that all legal requirements applicable to such information have been complied with. In the event that KEW receives insufficient quantity of tissue specimen, KEW will contact the pathologist and ordering physician. In the event that KEW does not receive adequate tissue specimen, KEW may not be able to perform the test and in such an event KEW will not charge for the Services.

INFORMATION ON CANCERPLEX® PRODUCTS

CANCERPLEX® FP (Full Panel) is an NGS test covering 400+ genes for solid tumors. Includes micro-satellite instability (MSI) status, tumor mutation burden (TMB), and viral status of HPV16/18 and EBV.

CANCERPLEX® TX covers all known genes for which there are FDA-approved targeted oncology therapies in solid tumors*. There are currently 66 genes included for targeted therapeutics. Includes micro-satellite instability (MSI) status, tumor mutation burden (TMB), and viral status of HPV16/18 and EBV.

CANCERPLEX® TS encompasses six (6) tumor specific panels which cover all current therapeutic targets including FDA-approved and those under clinical investigation. Includes micro-satellite instability (MSI) status, tumor mutation burden (TMB), and viral status of HPV16/18 and EBV.

**does not include all anti-angiogenesis agents*

Gastrointestinal (GI) ***Colorectal, Anal, Esophageal, Gastric, Hepatic, Biliary and Pancreatic*** Somatic mutation detection for cancer therapies in GI Tumors N=70+ genes	**Melanoma & Skin** Somatic mutation detection for cancer therapies in cutaneous basal cell carcinoma and melanoma N=70+ genes
Gynecologic (GYN) & Breast ***Ovarian, Uterine, Endometrial and Breast*** Somatic mutation detection for therapies in women's cancers, includes BRCA and DNA repair genes N=75+ genes	**Genitourinary (GU)** ***Renal, Urothelial, and Prostate*** Somatic mutation detection for therapies in kidney, prostate and urothelial cancers N=85+ genes
Lung ***NSCLC, SCLC and Mesothelioma*** Somatic mutation detection for cancer therapies in lung cancers N=70+ genes	**Head & Neck** Somatic mutation detection for cancer therapies in head & neck cancers N=60+ genes

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