NORTHSTAR BY BILLIONTOONE

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REQUISITION FORM

TEST MENU

		# OF BLOOD TUBES NEEDED
Northstar	**Therapy Selection + Therapy Response Monitoring**	UUU
☐ **Northstar Select™**	Plasma-based genomic profiling assay for solid tumors	UU
☐ **Northstar Response™**	Plasma-based therapy response monitoring assay	UU

SAMPLE COLLECTION DATE & BARCODE

MM-DD-YYYY REQUIRED

PLACE BARCODE HERE

PATIENT INFORMATION

*Shaded fields must be completed. * By providing phone number and email address, patient consents to be contacted for test status, billing/collection, quality assurance, or research purposes.*

First Name REQUIRED | MI | Last Name REQUIRED | Date of Birth (MM-DD-YYYY) REQUIRED | Sex REQUIRED | Medical Record # | Phone Number *

Street Address | Apt / Unit / Suite | City | State | Zip Code | Email Address *

PATIENT HISTORY

Shaded fields must be completed.

Disease status at time of testing: *Select all that apply* REQUIRED

☐ Metastatic ☐ Recurrent ☐ Relapsed ☐ Refractory ☐ Other specify

☐ Pathology report attached REQUIRED FOR FIRST ORDER

☐ Patient is currently on therapy

Date of Initiation: MM-DD-YYYY

Therapy Type: ☐ Targeted ☐ Immuno ☐ Chemo ☐ Combination

☐ Patient has received transplant

DIAGNOSIS

Shaded fields must be completed.

Date of Original Diagnosis (MM-DD-YYYY) REQUIRED

Stage at Diagnosis: REQUIRED

☐ I ☐ II ☐ III ☐ IV

ICD-10 Code(s) REQUIRED

Diagnosis: *Select only one (primary tumor)* REQUIRED

☐ Non-Small-Cell Lung Carcinoma
☐ Breast Carcinoma
☐ Colorectal Adenocarcinoma
☐ Prostate Adenocarcinoma
☐ Ovarian Carcinoma
☐ Skin Melanoma
☐ Other specify

RELEVANT CLINICAL HISTORY

All fields must be completed for medical coverage determination.

The patient is seeking further treatment and is: REQUIRED ☐ Newly diagnosed (Stage III/IV) ☐ Not responding to therapy

Was a commercial liquid biopsy test for therapy selection ordered for the patient since their most recent progression? REQUIRED ☐ No ☐ Yes

Is tissue-based comprehensive genomic profiling (CGP) from a recent biopsy feasible? REQUIRED ☐ No ☐ Yes

Has tissue-based CGP from a recent biopsy been performed and a test result that is not Test-Not-Performed was provided? REQUIRED ☐ No ☐ Yes

Has tissue-based CGP from a recent biopsy already returned an actionable result? REQUIRED ☐ No ☐ Yes

Other

PATIENT BILLING INFORMATION

Select one option and provide necessary details.

☐ **Medicare (Part B)**

Medicare Policy ID #

Patient status at time of specimen collection:

☐ Hospital Outpatient
☐ Hospital Inpatient, Discharged on MM-DD-YYYY

☐ **Other Insurance**

Plan Name

Policy # | Group # | Prior Authoization #

☐ **Self-Pay / Uninsured**

Contact Name | Phone

Email Address

☐ **Hospital / Institution (Client Bill)**

☐ Same address as treating physician

Street Address

City | State | Zip Code

TREATING PHYSICIAN INFORMATION

Shaded fields must be completed.

Facility Name REQUIRED | Treating Physician Full Legal Name REQUIRED

Facility Phone REQUIRED | Facility Fax | BillionToOne Account #

Is the facility a hospital, hospital outpatient department, critical access hospital or ambulatory surgical center? ☐ Yes ☐ No

If yes, what is the facility's network status with the patient's insurance plan? ☐ In-network ☐ Out-of-network

PHYSICIAN SIGNATURE & CONSENT REQUIRED

By submission of this requisition and accompanying sample(s), I hereby authorize and direct BillionToOne to: (1) utilize the above information to process the indicated test for this patient, and (2) release the results and patient information to the patient's third-party payer, as needed. I certify that: (1) all information provided herein is true and accurate, (2) I am authorized by law to request the test, (3) the test is reasonable and medically necessary for the treatment and management of this patient, (4) the patient has been counseled on the potential results, benefits and limitations of the test, and (5) I have obtained informed consent to the extent required under applicable law. I agree to provide the necessary information and medical records to BillionToOne needed to submit and process claims to payers.

Physician Signature | Printed Name | Date (MM-DD-YYYY)

TEST PANEL	TEST DETAILS	SAMPLE REQUIREMENT
Northstar Select™	Blood-based 84-gene NGS therapy selection assay, including MSI, for all solid tumors	**2** X 10 mL tiger-top Streck cell-free DNA BCT® blood tube **Fill to the top (≥ 8mL)**
Northstar Response™	Blood-based therapy response monitoring assay for all solid tumors	**2** X 10 mL tiger-top Streck cell-free DNA BCT® blood tube **Fill to the top (≥ 8mL)**

PATIENT ACKNOWLEDGEMENT

I have been informed of and understand the details of the tests ordered herein for me by my healthcare provider, including the risks, benefits and alternatives, and have consented to testing. I understand that: (1) the test results may inform me of a medical condition that may require follow-up, and (2) a negative result does not rule out the possibility of such medical condition in me. I hereby authorize: (1) the release to BillionToOne of any medical and insurance information necessary to process claims and recover reimbursement claims for services provided by BillionToOne, and (2) BillionToOne to pursue all necessary appeals of any full or partial denials of payment in relation to services provided by BillionToOne. I understand that the test may not be: (1) covered by my insurer/health plan, or (2) deemed medically necessary; and I am responsible for any costs not paid by my plan directly to BillionToOne, including, without limitation, any copayments, deductibles, or amounts deemed 'patient responsibility'. BillionToOne may contact my healthcare provider to obtain more information regarding clinical correlation and confirmatory testing.

Patient Signature

MM-DD-YYYY

Date of Acknowledgement

BEFORE YOU SHIP, please ensure that:

- ☑ **Test panel** is selected and **ICD10 codes** are filled
- ☑ **Required fields** on this form are completed
- ☑ **Insurance card copies** are included (front and back)
- ☑ **Provided barcode** is affixed to tubes and this form
- ☑ Requisition is **signed**

Call **1-800-463-3339 (1-800-GO FEDEX)** to schedule a pickup