NORTHSTAR by BILLIONTOONE

REQUISITION FORM

TEST MENU

☐ **Northstar Select®** Blood-based genomic profiling assay for **Therapy Selection** (for solid tumors)

☐ **Northstar Response®** Blood-based assay for **Therapy Response Monitoring** (for solid tumors)

- ☐ Run Northstar Select upon molecular progression (i.e. an increase in Northstar Response Tumor Methylation Score)
- Draw schedule: †

Every ☐ 4 weeks ☐ 6 weeks ☐ 3 months ☐ 6 months ☐ enter custom draw schedule _____

Indicate the total number of draws _____

Testing is for 12 months unless total number of draws is entered.

If no recurring schedule is checked, the order will be treated as a single time order.

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 REQUIRED (MM-DD-YYYY) | Sex REQUIRED | Medical Record # | Phone Number *

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

PATIENT HISTORY

Shaded fields must be completed.

☐ **Advanced cancer stage** REQUIRED — earlier stages currently not accepted
(i.e. Stage III/IV generally or Stage IIIB/IV NSCLC)

☐ **Pathology report attached** REQUIRED — for first order

If patient is currently on therapy, provide initiation date and type: MM-DD-YYYY

☐ Immunotherapy ☐ Targeted therapy ☐ Chemotherapy ☐ Combination therapy

DIAGNOSIS

Shaded fields must be completed.

MM-DD-YYYY
Date of Original Diagnosis REQUIRED

ICD-10 Code(s) REQUIRED

Diagnosis REQUIRED
Select only one (primary tumor)

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

RELEVANT CLINICAL HISTORY

REQUIRED for Northstar Select only *All fields must be completed for medical coverage determination.*

The patient is seeking further treatment and is	☐ 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?	☐ No	☐ Yes
Is tissue-based comprehensive genomic profiling (CGP) from a recent biopsy feasible?	☐ No	☐ Yes
Has tissue-based CGP from a recent biopsy been performed with a non-QNS result?	☐ No	☐ Yes
Has tissue-based CGP from a recent biopsy already returned an actionable result?	☐ No	☐ Yes

Other _____

PATIENT BILLING INFORMATION

Select one option and provide necessary details.

☐ Medicare (Part B)
Medicare Policy ID #

☐ Other Insurance
Plan Name
Policy # | Group #

☐ Self-Pay / Uninsured
Contact Name | Phone
Email Address

☐ Hospital / Institution (Client Bill)
☐ Same address as treating physician
Street Address
City | State | Zip Code

PATIENT ACKNOWLEDGMENT SIGNATURE

I acknowledge that I have read and agreed to the Patient Acknowledgment for testing on the back page.

Patient Signature | MM-DD-YYYY Date

TREATING PHYSICIAN INFORMATION

Shaded fields must be completed.

Facility Name REQUIRED

Facility Phone REQUIRED | Facility Fax | BillionToOne Account #

Treating Physician Full Legal Name REQUIRED | Treating Physician Email Address

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

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 | MM-DD-YYYY Date

† If you would like to cancel any order, please call our support number at 833.537.1819 and we would be more than happy to assist you.

To mitigate the need for redraw, a **total of 3 tubes is preferred** where possible for all ordering scenarios.

TEST PANEL	TEST DETAILS	MINIMUM SAMPLE REQUIREMENT
Northstar Select®	Blood-based 84-gene NGS therapy selection assay, including MSI, for all solid tumors	**2 x** 10mL Streck cell-free DNA BCT® blood tube **Fill to the top (≥ 8mL)**
Northstar Response®	Blood-based therapy response monitoring assay for all solid tumors	**1 x** 10mL Streck cell-free DNA BCT® blood tube **Fill to the top (≥ 8mL)**

PATIENT ACKNOWLEDGMENT

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.

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

T 833.537.1819 E support@northstaronc.com northstaronc.com