NORTHSTAR BY BILLIONTOONE

REQUISITION FORM

TEST MENU

☐ **Northstar Select®** Blood-Based Genomic Profiling Assay for **Therapy Selection** (for Solid Tumors)

- ☐ **Add Northstar Select CH™:** Order Clonal Hematopoiesis (CH) testing †
- ☐ **Add Northstar PGx™:** Order Pharmacogenomics (PGx) testing (includes *DPYD* and *UGT1A1*)

☐ **Northstar Response®** Blood-Based Assay for **Therapy Response Monitoring** (for Solid Tumors)

- Recurring Draw Schedule: ‡
  Every: ☐ 4 weeks ☐ 6 weeks ☐ 3 months ☐ 6 months ☐ custom _____ Total number of draws _____
  If blank, testing is for 12 months
- ☐ Run **Northstar Select** upon molecular progression for initial and recurring tests
  (i.e. an increase in Northstar Response Tumor Methylation Score)
  - ☐ **Add Northstar Select CH:** Order Clonal Hematopoiesis (CH) testing †

SAMPLE COLLECTION DATE & BARCODE

MM-DD-YYYY *

PLACE BARCODE HERE

PLACE IDENTIFIERS HERE

† When ordered, CH buffy coat gDNA sequencing (Northstar Select CH) will be run only if an eligible CH-prone alteration is identified by Northstar Select and not more than once in a 12 month period. Other alterations will be classified via bioinformatics (Northstar CH™).

‡ If you would like to cancel any order, please call our support number at 833-537-1819.

First Name * | MI | Last Name * | Date of Birth * (MM - DD - YYYY) | Sex * | 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 * earlier stages currently not accepted
(i.e. Stage III/IV generally or Stage IIIB/IV NSCLC)

☐ Pathology report attached * 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.*

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

ICD-10 Code(s) *

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

- ☐ 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: _____ ☐ 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 #

Plan Name

☐ Other Insurance
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 ACKNOWLEDGEMENT SIGNATURE

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

Patient Signature | Date (MM-DD-YYYY)

TREATING PHYSICIAN INFORMATION *Shaded fields must be completed.*

Facility Name *

Facility Phone * ((123) - 555.1234) | Facility Fax | BillionToOne Account #

Treating Physician Full Legal Name * | 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 | Date (MM-DD-YYYY)

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. Optional: **Northstar Select CH** evaluates hematopoietic origin (tumor vs non-tumor) of eligible CH-prone alterations when detected by Northstar Select, and will be performed when ordered by a physician; this test will not be performed more than once in a 12 month period. Other alterations will be classified via bioinformatics (Northstar CH). Optional: **Northstar PGx** testing evaluates key pharmacogenomic variants in *DPYD* and *UGT1A1* and is performed only when ordered by a physician.	**2 ×** 10 mL 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 ×** 10 mL 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.

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

BILLIONTOONE
NS-TRF-010-2602

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