GUARDANT HEALTH®

clientservices@guardanthealth.com | 1.855.698.8887
NPI # 1184045619 | CLIA # 05D2070300 | CAP Accredited # 8765297

Place Barcode Here

International Guardant360 Test Requisition

All shaded boxes MUST be filled in.

1. PATIENT INFORMATION

Last Name | First Name

DOB (dd/mm/yyyy) | Gender ☐ F ☐ M | Medical Record Number

Street Address

City | Province | Country | Postal Code

Preferred Contact Phone Number | E-Mail

☐ New Guardant360 Patient ☐ Existing Guardant360 Patient

2. SPECIMEN INFORMATION (Only whole blood specimens accepted)

Collection Date (dd/mm/yyyy) | Name of Person Collecting Specimen

3. STAGE (Box must be checked) Stage I/II not currently accepted

☐ Advanced cancer (Stage III/IV) | Currently on therapy? If yes, please list below.

4. ORDERING PHYSICIAN (or other Licensed Medical Professional)

Last Name | First Name

Hospital/Institution

E-mail

Account Name: NewBridge Pharmaceuticals FZ LLC
Account Number: GHI-018890
Account Address: Business Central Tower A
18th Floor
City: Dubai Internet City
State/Province: Dubai
Zip Code: 000
Country: AE
Phone Number: +971-4-4506911
Fax

Medical Professional Consent

My signature constitutes a Certification of Medical Necessity, and I hereby authorize and order Guardant Health, Inc. (GH) to perform Guardant360 testing and curation for this patient as indicated on this requisition. I have reviewed the medical consent on the back of this form and will provide test interpretation to the patient as appropriate. *(continued at the bottom)*

Medical Professional Signature | Date

X

Guardant Health's goal is to provide a laboratory report with personalized information for each patient based on the genomic alterations detected by the **Guardant360®** test and on the patient's diagnosis (cancer type). In order to provide the most accurate and comprehensive information on the laboratory report, we require the exact pathologic diagnosis of the **primary tumor** to be selected as follows:

5. DIAGNOSIS (MUST choose one)

BRAIN
- ☐ Glioblastoma
- ☐ Other Primary CNS Tumor ▶ _____

BREAST
- ☐ Breast Carcinoma

GENITOURINARY
- ☐ Bladder Carcinoma
- ☐ Prostate Adenocarcinoma
- ☐ Renal Cell Carcinoma
- ☐ Renal Pelvis Urothelial Carcinoma

GI
- ☐ Appendiceal Adenocarcinoma
- ☐ Cholangiocarcinoma
- ☐ Colorectal Adenocarcinoma
- ☐ Esophageal Adenocarcinoma

GI continued
- ☐ Esophageal Squamous Cell Carcinoma
- ☐ Gastric Adenocarcinoma
- ☐ Gastroesophageal Junction Adenocarcinoma
- ☐ (GIST) Gastrointestinal Stromal Tumor
- ☐ Hepatocellular Carcinoma
- ☐ Pancreatic Ductal Adenocarcinoma
- ☐ Pancreatic Neuroendocrine Tumor
- ☐ Other Gastrointestinal Tumor ▶ _____

GYNECOLOGIC
- ☐ Cervical Squamous Cell Carcinoma
- ☐ Endometrial Carcinoma
- ☐ Ovarian Carcinoma

HEAD & NECK
- ☐ Head and Neck Carcinoma

LUNG
- ☐ Adenocarcinoma (NSCLC)
- ☐ Large Cell Carcinoma (NSCLC)
- ☐ Squamous Cell Carcinoma (NSCLC)
- ☐ Lung Carcinoid/Neuroendocrine
- ☐ Small Cell Lung Carcinoma
- ☐ Other Lung Tumor ▶ _____

Please check smoking status
- ☐ Never/Light smoker
- ☐ Heavy smoker (>15 pack-years)

SARCOMA
- ☐ Sarcoma ▶ _____

SKIN
- ☐ Basal Cell Carcinoma
- ☐ Squamous Cell Carcinoma
- ☐ Melanoma

THYROID
- ☐ Thyroid Carcinoma

OTHER
- ☐ Carcinoma of unknown primary (CUP)
- ☐ Other ▶ _____

6. RELEVANT CLINICAL HISTORY

Date of original diagnosis (dd/mm/yyyy)

Tissue unavailable for Genotyping? ☐ Yes ☐ No
If no, please state reason:

Prior Testing?

	Pos	Neg	Unavailable		Pos	Neg	Unavailable		Pos	Neg	Unavailable
EGFR	☐	☐	☐	*BRAF*	☐	☐	☐	*KRAS*	☐	☐	☐
ALK	☐	☐	☐	*MET*	☐	☐	☐	*NRAS*	☐	☐	☐
RET	☐	☐	☐	*ERBB2* (HER2)	☐	☐	☐	*KIT*	☐	☐	☐
ROS1	☐	☐	☐					*PDGFRA*	☐	☐	☐

If positive, list mutation:

IF AVAILABLE, provide copy of Pathology/ Cytology Report and IHC, FISH, or other Molecular Assay Test Results.

7. BILLING INFORMATION

☐ Hospital/Institution ☐ Distributor Project code ▶ _____

GENERAL COMMENTS:

Medical Professional Consent *(continued from top)* I have determined that the Guardant360 test is medically necessary, and I hereby authorize GH to perform testing for this patient as indicated on this requisition. I have supplied information to the patient regarding somatic genomic testing and the patient has given consent for this testing to be performed by GH and for the results to be reported back to me. I understand that GH is relying only on the diagnosis that I provide on the test requisition form in providing information about potential therapeutic options and clinical trials associated with the reported genomic testing results, and that an incorrect diagnosis would adversely affect the relevance of the information provided by GH.

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