Print Form

Customer Order Number _____ Customer ID _____ Program ID _____

Test Requisition Form

Please send to FoundationNavigate by email: FoundationNavigate@patientassistance.ca **or by fax:** 1-888-650-4836
All fields required | For more information visit *www.foundationmedicine.ca*

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Patient Demographics

Last Name | First Name | MI | Medical Record # | DOB *(MM/DD/YYYY)* | Sex ☐ F ☐ M

Address | City/Province/Postal Code | Country | Phone *(primary)*

Treating Physician Information

Facility Name _____ Treating Physician *(full legal name)* _____

Facility Address | City/Province/Postal Code | Country

Phone | Fax | Email | Account #

Additional Physician to be Copied *(optional)* | Facility Name | Email | Fax

Current Diagnosis/Patient History

Diagnosis: ☐ NSCLC ☐ Melanoma ☐ Colorectal Carcinoma ☐ Ovarian ☐ Breast ☐ Prostate ☐ Other _____

Disease Status *(select all that apply)*: ☐ Metastatic ☐ Recurrent ☐ Refractory ☐ Relapse ☐ None of these options

Additional Details _____ Stage_____ ICD Codes *(only codes beginning C or D accepted)* _____

Transplant Information _____ Targeted Therapies _____

Attachments: ☐ Copy of recent pathology/cytology reports including (if available/applicable), CBC/differential, BMA differential, FAB classification.
☐ Test results from all other Molecular Diagnostic Assays by FISH, IHC, or other genetic assays, e.g., *ER, PR, HER2, EGFR, KRAS,* etc.

Test Selection | *Select one*

Genomic test	*Description*	*Accepted Specimen Type*
◯ **FoundationOne®CDx**	Tissue biopsy for all solid tumours	FFPE Tissue
◯ **FoundationOne®Liquid CDx**	Liquid biopsy for all solid tumours	Peripheral Whole Blood
◯ **FoundationOne®Heme**	For hematologic malignancies & sarcomas	Peripheral Whole Blood, Bone Marrow Aspirate, FFPE Tissue, Extracted Nucleic Acid

Additional Option

◯ **IHC Testing PD-L1** *(Scoring and clone utilization based on FDA-approved indications. See back of this document for information)* ..... FFPE Tissue

Specimen Retrieval | *Only one specimen can be tested per order*

Submitting Pathologist Name | Pathology Lab Name | Phone | Fax | Email

☐ Specific specimen requested ☐ Let the submitting pathologist choose specimen

→ Date of Collection *(MM/DD/YYYY)*_____ Specimen ID_____ Specimen Site _____ Alternate Choice _____ *Optional*

◯ **FFPE Tissue**
(for FoundationOne®CDx and FoundationOne®Heme)
→ ☐ I will arrange for the specimen to be shipped to Foundation Medicine.
→ ☐ Contact the pathology lab to obtain specimen.

◯ **Peripheral Whole Blood**
(for FoundationOne®Liquid CDx)
→ ☐ I will arrange for the specimen to be shipped to Foundation Medicine.
→ ☐ Phlebotomy Service requested (contact FoundationNavigate for details)

◯ **Bone Marrow Aspirate/Extracted Nucleic Acid**
(for FoundationOne®Heme)
→ ☐ I will arrange for the specimen to be shipped to Foundation Medicine.
→ ☐ Contact the pathology lab to obtain specimen.

◯ **For FoundationOne®CDx or FoundationOne®Liquid CDx** (If specimen submitted is insufficient for analysis, use portfolio reflex option — see back for details.)

Payment Contact Information

Payor Name	
Payor Address	
Payor Phone Number	Payor Email Address

Certificate of Medical Necessity/Consent/Test Authorization and Physician Signature

My signature constitutes a Certificate of Medical Necessity, certifies that this test information will inform the patient's ongoing treatment plan, and certifies that I am the patient's treating physician. I have explained to the patient the nature and purpose of the testing to be performed and have obtained informed consent, to the extent legally required, to permit Foundation Medicine to **(a)** perform the testing specified herein, **(b)** retain the test results for an indefinite period for internal quality assurance/operations purposes, **(c)** de-identify the test results and use or disclose such de-identified results for future unspecified research or other purposes, **(d)** release the test results to the patient's third-party payer as needed for reimbursement purposes, and **(e)** release information to third-party agents of Roche or FMI for payment processing, including by obtaining my patient's signature on the Patient Authorization and Consent form provided by Roche.

My signature also authorizes Foundation Medicine to select the most appropriate test (pursuant to Foundation Medicine's Change in Test Authorization Policy) based on requisition/pathology information.

Treating Physician Signature | Printed Name *(Full legal name)* | Date *(MM/DD/YYYY)*

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FFPE Block Return Information

FFPE Block Return Address

City | Province | Postal Code | Country

Email

Phone Number | Fax Number

FFPE Block Return Information

For information on ICD codes, visit this website:
https://icd10cmtool.cdc.gov/

Portfolio Reflex Option:
If the "Portfolio Reflex" checkbox is selected, we will proceed with the initial NGS test selected and if the specimen does not meet the criteria for successful testing, a new test requistion form will be required to procure a new specimen. The failed test is not billed, and the successful test will be billed according to our standard practices.

Additional Case Information *(optional)*:

Technical Information

FOUNDATION**ONE® CDx**

About the Test FoundationOne®CDx is a next-generation sequencing based *in vitro* test for detection of substitutions, insertion and deletion alterations, and copy number alterations in 324 genes and select gene rearrangements, as well as genomic signatures including microsatellite instability (MSI) and tumour mutational burden (TMB) using DNA isolated from formalin-fixed, paraffin-embedded (FFPE) tumour tissue specimens. For the complete Intended Use Provincement, please see the FoundationOne®CDx Technical Information page: *www.foundationmedicine.com/f1cdx*.

FOUNDATION**ONE®LIQUID CDx**

About The Test FoundationOne®Liquid CDx is a next-generation sequencing based *in vitro* test for advanced cancer patients with solid tumours. The test analyzes 324 genes utilizing circulating cell-free DNA and is used to identify patients who may benefit from treatment with specific therapies in accordance with the approved therapeutic product labeling. Additional genomic findings may be reported and are not prescriptive or conclusive for labeled use of any specific therapeutic product. Use of the test does not guarantee a patient will be matched to a treatment. For the complete technical information, please visit *http://www.F1LCDxLabel.com*.

FOUNDATION**ONE® HEME**

About the Test FoundationOne®Heme combines DNA sequencing of 406 genes and RNA sequencing of 265 genes for patients with hematologic malignancies, sarcomas or solid tumours where sensitive fusion detection is desired. The test can be used by physicians to identify potential targeted therapy options, detect alterations in prognostic genes, and sub-classify sarcoma diagnoses.

IHC Testing

For tumours with no CDx indication, Foundation Medicine will perform PD-L1 testing using the Dako PD-L1 22C3 PharmDx assay. More information available at this web link: *https://www.foundationmedicine.com/info/detail/ihc-testing*.

For Urothelial Carcinoma (URC), if PD-L1 testing with the Ventana SP142 clone is preferred, please indicate that preference on the test requisition form or contact our team at FoundationNavigate@patientassistance.ca or by calling 1-888-650-4835.

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