IQlung™ TREATMENT GUIDANCE

Phone: **1.866.432.5930** | Fax: **1.866.432.3338**
Email: **CustomerSupport@biodesix.com**

ATTACH PATIENT ID LABEL HERE
(With Name, Date of Birth, and Draw Date)

Test Request Form

PATIENT INFORMATION (REQUIRED)

Patient Last Name:	Patient First Name:	
Address:		
City:	State:	Zip Code:
Date of Birth (MM|DD|YYYY):	Gender:	Phone:
Medical Record Number (MRN):		

PATIENT CHARACTERISTICS (REQUIRED)

Cancer Diagnosis (ICD-10 code):

Date of diagnostic procedure if Cancer Diagnosis is not available (MM|DD|YYYY):

Stage:
☐ Advanced Stage (Stage IIIB-IV NSCLC, Stage III-IV Other Cancer Types)
☐ Early Stage (Stage I-IIIA NSCLC, Stage I-II Other Cancer Types)

Disease Status:
☐ Metastatic ☐ Recurrent
☐ Refractory ☐ Relapse
☐ Progression ☐ None/New Dx

EGFR Sensitizing Mutation Status:
☐ Positive
☐ Negative
☐ Unknown

ECOG Performance Status: (if known)
☐ ECOG 0 ☐ ECOG 3
☐ ECOG 1 ☐ ECOG 4
☐ ECOG 2

Histology: (if known)
☐ Adenocarcinoma
☐ Squamous
☐ Other

TEST MENU (REQUIRED)

☐ **IQLung™ Treatment Guidance Testing***
Advanced Stage | GeneStrat NGS™ test will reflex to VeriStrat® proteomic test
Early Stage | GeneStrat® targeted test will reflex to VeriStrat® proteomic test

* If Stage is not provided by the time of specimen receipt, GeneStrat NGS test will commence and GeneStrat targeted test may require a new specimen to be collected.

Select the **IQLung™ Treatment Guidance Testing** above OR the individual options below

Tumor Mutation Testing

☐ **GeneStrat NGS™** Genomic Test Only
☐ **GeneStrat®** Targeted Genomic Test Only (ddPCR)
Or check individual markers to test specific mutations:
☐ EGFR ☐ ALK ☐ ROS1 ☐ RET ☐ KRAS ☐ BRAF

Host Immune Profile Testing

☐ **VeriStrat®** Proteomic Test Only

TREATMENT PLAN (OPTIONAL)

Prior to receiving test results, which treatments would you consider for this patient (check all that apply)

☐ Targeted Drug Therapy (e.g. erlotinib, osimertinib)
☐ Single Agent Immunotherapy (e.g. pembrolizumab)
☐ Immunotherapy and Chemotherapy Combinations
☐ Immunotherapy combinations
☐ Platinum Doublet Chemotherapy
☐ Single Agent Chemotherapy
☐ Radiation Therapy
☐ Palliative Care
☐ Supportive Care | Hospice
☐ Other (please specify):

PHYSICIAN INFORMATION (REQUIRED)

Office | Practice:		
Ordering Physician:		
Address:		
City:	State:	Zip Code:
Office | Practice Primary Contact:	Phone:	Fax:
Office | Practice Secondary Contact:	Phone:	Fax:

Test Result Delivery:
☐ Encrypted Email ☐ Fax
☐ Copy Secondary Contact ☐ Physician Portal

Email Address:

By selecting any of these test delivery options, you are authorizing the electronic delivery of test results by Biodesix in accordance with the Health Insurance Portability and Accountability Act and the rules reflected in the HITECH Act.

BLOOD DRAW INSTRUCTIONS (REQUIRED)

Select the location of blood draw
☐ Coordinate Home Phlebotomy (Fax this form to 1.866.432.3338)
☐ In Office (non-hospital)
☐ Veteran's Affairs (VA) Facility
☐ Independent Lab (enter name):
☐ Ambulatory Surgery Center
☐ Hospital (inpatient)
☐ Hospital (outpatient)
☐ Independent Phlebotomist (enter name):

For Phlebotomist Use Only
☐ I, the phlebotomist, verify that the enclosed specimen was collected and processed according to the protocol provided by Biodesix. I verify that this specimen is the specimen taken from the patient named on this form.

Initial: Date (MM|DD|YYYY):

BILLING INFORMATION (REQUIRED)

Check Only One Box
☐ Patient insurance information is ATTACHED (please attach a copy of the patient's insurance card and/or Face Sheet if possible)
☐ Patient does not have insurance (please complete the financial assistance application included in test kit and attach a copy)

VeriStrat test uses CPT code 81538 for billing purposes. GeneStrat NGS test uses CPT Code 81455 for billing purposes. GeneStrat test uses CPT codes 81235 (EGFR), 81401 (ALK & RET), 81479 (ROS1), 81275 (KRAS), and 81210 (BRAF) for billing purposes.

AUTHORIZATION AND CERTIFICATION OF MEDICAL NECESSITY (REQUIRED)

Your signature constitutes a certification of medical necessity and intent to consider and use the results of the test(s) ordered. All of the information on this form is true and correct. You have obtained patient consent and authorize Biodesix to use and release the results and patient information for reimbursement purposes and as may be appropriate for additional clinical testing services.

Signature of treating physician or authorized representative. Date (MM|DD|YYYY):

Medicare Signature Requirements for providers define a valid signature as "handwritten or electronic." Please provide a wet ink or electronic signature on this form. If you are unable to do so, please contact Biodesix Customer Care at 1.866.432.5930.

INTERESTED IN ONLINE ORDERING AND TEST DELIVERY?

Contact Customer Care at 1.866.432.5930 to learn more about the Biodesix Physician Portal.

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