

Guardant360® and Guardant Reveal™ Therapy Response Monitoring Test Requisition

All shaded boxes are REQUIRED to be completed

1. PATIENT INFORMATION

Last Name		First Name	
DOB (dd/mm/yyyy)	Sex ☐ F ☐ M	Medical Record Number / Patient ID	
Street Address			
City	State	Country	Postal Code
Preferred Contact Phone Number			
☐ New Guardant Health Patient ☐ Existing Guardant Health Patient			

2. BLOOD SPECIMEN INFORMATION

Collection Date (dd/mm/yyyy)	Name of Person Collecting Specimen
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3. ADVANCED CANCER STAGE (REQUIRED) Stage I/II not currently accepted

☐ Advanced Cancer (Stage III/IV)

Currently on Therapy? If yes, please list below (REQUIRED for Therapy Response Monitoring)
Select more than one if patient is being treated with combination regimen.

☐ Targeted Therapy ☐ Immunotherapy ☐ Chemotherapy ☐ Endocrine Therapy

Specific therapy ▶

4. ORDERING PHYSICIAN (or other Licensed Medical Professional)

Last Name		First Name	
Hospital / Institution			
Email			
Account Name Gene Agnostic Co., Ltd.		Account Number GHI-035253	
Account Address 300/139 Soi Ladprao 84 District Wang Thong Lang			
City Bangkok		State / Province	
Postal Code 10310		Country TH	
Phone Number		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 on back)

Medical Professional Signature

Date

X

5. TEST SELECTION (REQUIRED; SELECT ONE)

☐ 74-Gene Panel Guardant360 74-gene panel including: • Microsatellite instability (MSI) status  Barcode is for Internal Use Only	OR	☐ 700+ Gene Panel Guardant360 Expanded-gene including • Microsatellite instability (MSI) status • Blood tumor mutational burden (bTMB) • Expanded coverage of homologous recombination repair (HRR) genes  Barcode is for Internal Use Only	OR	☐ Therapy Response Monitoring Guardant Reveal Therapy Monitoring Therapy response monitoring: Utilizes ctDNA to evaluate response to therapy.  Barcode is for Internal Use Only
Date of Therapy Initiation (dd/mm/yyyy) ▶				

6. DIAGNOSIS (REQUIRED to select one)

Date of original diagnosis (dd/mm/yyyy) _____ BRAIN ☐ Glioblastoma ☐ Other Primary CNS Tumor ▶ _____ BREAST ☐ Breast Carcinoma ☐ Other Breast Tumor ▶ _____	GENITOURINARY ☐ Bladder Carcinoma ☐ Prostate Adenocarcinoma ☐ Renal Cell Carcinoma ☐ Urothelial Carcinoma ☐ Other Genitourinary Tumor ▶ _____ GI ☐ Cholangiocarcinoma ☐ Colorectal Adenocarcinoma ☐ Esophageal/Gastroesophageal Junction Adenocarcinoma ☐ Gastric Adenocarcinoma ☐ Hepatocellular Carcinoma ☐ Pancreatic Ductal Adenocarcinoma ☐ Other Gastrointestinal Tumor ▶ _____	GYNECOLOGIC ☐ Endometrial Carcinoma ☐ Ovarian Carcinoma ☐ Other Gynecologic Tumor ▶ _____ HEAD & NECK ☐ Head and Neck Carcinoma LUNG ☐ Adenocarcinoma (NSCLC) ☐ Large Cell Carcinoma (NSCLC) ☐ Squamous Cell Carcinoma (NSCLC) ☐ Small Cell Lung Carcinoma ☐ Other Lung Tumor ▶ _____	SARCOMA ☐ Sarcoma ☐ Other Sarcoma ▶ _____ SKIN ☐ Melanoma ☐ Other Skin Tumor ▶ _____ THYROID ☐ Thyroid Carcinoma OTHER ☐ Carcinoma of Unknown Primary (CUP) ☐ Other ▶ _____
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7. RELEVANT CLINICAL HISTORY

1. The patient is seeking treatment and: ☐ is newly diagnosed (Stage III/IV). ☐ has tumor that is not responding to therapy. If positive, list mutation: _____

2. Has tissue- or liquid-based CGP from a recent biopsy already returned an actionable result? ☐ No ☐ Yes _____

8. BILLING INFORMATION

☐ Hospital/Institution ☐ Distributor Project Code ▶ _____



LBL-000317 R3

Test Requisition & Statement of Medical Necessity *continued***4. Medical Professional Consent** *(continued from front)*

I have informed the patient regarding somatic genomic testing, and the patient has consented for the tests ordered. The patient understands that his/her anonymized results may be used by GH for the purpose of laboratory test improvement and publication of aggregated data. I understand that GH is relying on the diagnosis I have provided on the test requisition form in providing information about potential therapeutic options and clinical trials associated with the reported testing results, and that an incorrect diagnosis would adversely affect the relevance of the information provided by GH. I understand that I remain free in my medical decisions on how to use the results of any Guardant Health product(s) in my management of this patient. I have obtained the patient's written consent to transmit the health data on this requisition form for the purpose of processing this order and performing all ordered Guardant Health tests.

Patient Consent

Your healthcare provider has ordered certain tests offered by Guardant Health, Inc. (GH)(the "Tests").

The Tests may detect both somatic (not inherited) and germline (inherited) alterations; however, the Tests do not distinguish between such mutations. Therefore, the Tests do not provide information about propensity to develop disease in the future. However, if a reported alteration is suspected to be germline, confirmatory hereditary testing should be considered in the appropriate clinical context. These Tests are not intended to replace germline testing or to provide information about cancer predisposition. Your healthcare provider will consider whether follow up confirmatory germline testing is appropriate for you. You may wish to discuss with your healthcare provider about seeking genetic counseling from a genetic counselor before undergoing germline testing.

By signing below, you consent to undergo the Test and you acknowledge and/or agree that:

- You have been informed by your physician about the purpose, scope, and limitations of the test ordered. The Test reports do not provide a definitive medical diagnosis or make any specific treatment recommendations; instead they provide information for your healthcare provider to review. GH does not guarantee that a Test will yield clinically relevant information, inform your healthcare provider's clinical decision-making, or otherwise lead to any particular or beneficial outcome. Some Test results may show one or more "actionable" genomic alterations, meaning that there may be: (i) FDA-approved therapies available that target a specific disease subtype; (ii) certain clinical trials available to you; or (iii) genetic information that may impact your ongoing healthcare management. The Tests do not examine every possible genetic variant and may not identify all variants related to you or your disease, because: (i) there is a possibility of testing errors; (ii) biological factors may limit the accuracy of results; or (iii) the presence of a mutation may be below the limit of detection for the Tests. GH is not obligated to update, revisit, or later re-evaluate Test results after they have been sent to your healthcare provider.
- You authorize release of pathology tissue samples, blood, and/or other materials, including extracted DNA and RNA, requested by GH ("Materials") to conduct the Tests, and direct the applicable pathology lab to release all such Materials to GH. You understand that your Materials will be collected and transported by third party logistics carriers to GH in the US for analysis and interpretation. You acknowledge that the Materials may be lost, delayed or damaged during handling or transit by third party logistics carriers, and assume all associated risks. You hereby release, waive, and discharge GH and its Affiliates from any and all claims, liabilities, or causes of action arising from loss or damage in transit. You further acknowledge that the Materials may be irreplaceable and the maximum liability of GH, if any, shall be limited to the amount paid by you for the Test.
- Your Materials, personal data, and health information will be transferred to GH in the United States, and the data protection laws in the United States may differ from those in your home country in how they safeguard your personal data.
- GH will be processing your personal data (including your Materials and health information). GH collects, uses, discloses, or processes your Personal Data for the following purposes as described in GH's Privacy Policy available at: <https://guardanthealth.com/contact/privacy-policy/>: (i) carrying out the Test; (ii) providing Test-related communications to you or your healthcare provider or institution; (iii) billing-related activities; (iv) managing GH's administrative and business operations; (v) carrying out your instructions; (vi) performing other permitted or reasonably related activities; and (vii) complying with GH's legal obligations and/or a government request. Carrying out the purposes will involve the overseas transfer and storage of your Personal Data, including to GH's facilities in the United States. Furthermore, subject to applicable law, GH may remove certain identifying information from your personal data (such as by de-identifying, pseudonymizing, or anonymizing your personal data) and process such data for its scientific research purposes related to cancer diagnostic product improvement and development, including publication of aggregated data. Certain third parties may process and store your personal data as detailed in GH's Privacy Policy, including third parties appointed by GH and/or its affiliates, necessarily involved in the process of ordering, taking, collecting, delivering, testing your sample and reporting.
- You understand that the results of the Test will be sent or made available to your physician, and when the results are ready, you will collect the Test results from your physician.
- You have read and understand the information set out above in this form, and that you: (i) had the opportunity to ask any questions that you might have regarding the Test and the process related to the Test; and (ii) received satisfactory answers from your physician.
- For patient under 18 years of age, you certify that you are the guardian of the patient and on behalf of the patient, you hereby agree for the patient to undergo the Test and for the patient's personal data to be processed as set out above.
- You authorize the below listed individual to have access to your personal data, including your health information, Test updates, and reports (Optional):

Full Name of Authorized Family Member: _____

Date of Birth (DOB) of Authorized Family Member: _____

Relationship status with the patient: _____

Phone number: _____

Email address: _____



SIGNATURE OF PATIENT

PRINT NAME OF PATIENT

DATE