Please select your finance billing type:

☐ **New** Guardant Patient	For **Existing** Guardant Patient, please check:	☐ Re-Test due to previous **No Mutation Detected (NMD)** Reporting (either Liquid/Tissue) (*Only eligible **within 8 weeks** after the NMD reporting) ☐ Previous user of Tissue / Liquid	☐ **Bundle Test (Liquid + Tissue)**

GUARDANT 360 Tissue

clientservicesamea@guardanthealth.com | +65.8940.0360
CLIA # 05D2070300 | CAP Accredited # 8765297 | FRM-PRT-000080 R4

Place Barcode Here

Guardant360 Tissue™ Test Requisition

All shaded boxes are REQUIRED to be completed

1. PATIENT INFORMATION

Last Name | First Name

DOB (dd/mmm/yyyy) | Sex ☐ F ☐ M | Medical Record Number

Street Address

City | State | Country | Postal Code

Preferred Contact Phone Number

☐ New Guardant Health Patient ☐ Existing Guardant Health Patient

2. ADVANCED CANCER STAGE (REQUIRED)

☐ Advanced Cancer (Stage III/IV)

3. ORDERING PHYSICIAN (or other Licensed Medical Professional)

Last Name | First Name

Hospital / Institution

Email

Account Name: Codex Genetics Limited | Account Number: GHI-029316

Account Address: 220 2/F Building 16W

City: Sha Tin | State / Province

Postal Code: 0 | Country: HK

Phone Number: +852 30082560 | Fax

4. TEST SELECTION (MUST choose one)

☐ Guardant360 Tissue + Tissue RNA

☐ Guardant360 Tissue + Tissue RNA + PD-L1

Select IHC test(s) to add: (At Additional Cost)

☐ ER/PR ☐ HER2 ☐ FOLR1
☐ CLDN18 ☐ c-Met ☐ Ki-67

Guardant360 Tissue is a comprehensive next-generation sequencing panel that interrogates 740+ genes and RNA fusions in 360+ genes, includes TMB, MSI status, and promoter methylation data (with/without additional IHC test(s)).

Medical Professional Consent

My signature certifies that: (1) the patient has received an explanation of the purpose, risks, and benefits of the ordered Test(s); (2) the ordered Test(s) are medically necessary and will inform the patient's treatment plan; and (3) the patient, by signing this form, has provided informed consent that meets requirements of applicable law for Guardant Health, Inc.(GH) (continued on back)

Medical Professional Signature | Date

X

5. SPECIMEN DETAILS (REQUIRED to complete details and attach patient's pathology report)

Please ensure that FFPE block(s) or unstained slides are provided as per specimen requirements.

Pathology Lab Name: Codex Genetics Limited

Specimen ID | Organ Site of Tissue Collection | Date of Tissue Collection (dd/mmm/yyyy) | Comments

6. DIAGNOSIS (REQUIRED to select one)

Date of original diagnosis (dd/mmm/yyyy)

BRAIN
☐ Glioblastoma

BREAST
☐ Breast Carcinoma

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

GI
☐ Cholangiocarcinoma
☐ Colorectal Adenocarcinoma
☐ Esophageal/Gastroesophageal Junction Adenocarcinoma
☐ Gastric Adenocarcinoma
☐ Hepatocellular Carcinoma
☐ Pancreatic Ductal Adenocarcinoma

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

SARCOMA
☐ Sarcoma

SKIN
☐ Melanoma

THYROID
☐ Thyroid Carcinoma

OTHER
☐ Other ▶

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.

2. Currently on Therapy? If yes, please list below | Date of Therapy Initiation (dd/mmm/yyyy) ▶

☐ Targeted Therapy ☐ Immunotherapy ☐ Chemotherapy ☐ Combination Therapy Specific Therapy ▶

3. Has tissue- or liquid-based CGP from a recent biopsy already returned an actionable result? ☐ No ☐ Yes If positive, list mutation:

8. BILLING INFORMATION

☐ Hospital/Institution ☐ Distributor Project Code ▶

GENERAL COMMENTS:

FRM-PRT-000080 R4

clientservicesamea@guardanthealth.com | +65.8940.0360
CLIA # 05D2070300 | CAP Accredited # 8765297 | FRM-PRT-000080 R4

Test Requisition & Statement of Medical Necessity *continued*

3. Medical Professional Consent *(continued from front)*

or its reference lab to: (a) collect and use the patient's samples (including genetic material) and health information and perform the ordered Test(s); (b) retain and use samples and health information in accordance with applicable law; and (c) de-identify such samples and information and use and share the resulting de-identified samples and information in accordance with applicable law. My signature constitutes a Certification of Medical Necessity, and I hereby authorize and order GH to perform testing and curation for this patient as indicated on this requisition. If no Test is selected, this indicates an order for Guardant360 Tissue+ Tissue RNA. I have reviewed the medical consent on this form and will provide Test interpretation to the patient as appropriate. As may be required by applicable laws and regulations, I have informed the patient regarding somatic genomic testing and immunohistochemistry (IHC) testing (if selected), 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 GH 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 GH tests. Where applicable, I authorize GH to release the report to the patient directly. By submitting this request, I acknowledge that personal data will be processed in accordance with to GH's privacy policy (www.GuardantHealth.com/contact/privacy-policy).

FFPE Block Return Information (For AMEA CS USE ONLY)

FFPE Block Return Address _____

City _____ State _____ Postal Code _____ Country _____

Phone _____ Email _____

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
DATE

PRINT NAME
EMAIL ID OF PATIENT

NAME OF PATIENT (IF DIFFERENT FROM THE SIGNATORY

FILL IN WHEN NECESSARY

[Fill this form ONLY when tissue specimen retrieval from third-party laboratory is needed]

Date: _____

To: Histopathology Laboratory, _____*(Hospital Name)*

RE: Sample Retrieval and Preparation for Cancer Tissue Testing for Patient _____*(Name)*, HKID:_____

To Whom It May Concern,

Please accept this letter as formal authorization to your laboratory to:

1. **Retrieve** archived tissue specimen(s) of the indicated patient,
2. **Prepare** the specimen(s) based on the specimen requirements of the selected test request, and
3. **Release** the prepared specimen(s) to the **Codex Genetics** in handling all test requisition documents to the third-party service provider and local logistics for sample pick-up and transportation.

<table>
<tr><th>NO. OF SLIDES REQUIRED</th><th>CORE REQUIREMENT</th></tr>
<tr><td>☐ For Guardant360 TissueNext + PDL1 Dako22C3:
<u>8</u> FFPE unstained coated slides

☐ Additional Guardant IHC Testing:
(*Please check the box for each additional test request)

<table><tr><th>Additional Biomarker</th><th>No. of additional slides required</th></tr><tr><td>☐ c-MET</td><td>+1</td></tr><tr><td>☐ HER2</td><td>+1</td></tr><tr><td>☐ Ki-67</td><td>+1</td></tr><tr><td>☐ ER/PR</td><td>+2</td></tr><tr><td>☐ FOLR1</td><td>+2</td></tr><tr><td>☐ CLDN18</td><td>+3</td></tr></table>
Total No. of Slides Required: _____</td><td><u>For all Guardant tests:</u>

• FFPE unstained coated slides, 5μm thick each
• Surface Area
  • Minimum: ≥ 2 mm^2
  • Optimum: 25mm^2
• Tumor Content
  • Minimum: ≥ 5%
  • Optimum: ≥ 20%

Pathology report is required.</td></tr>
<tr><td>☐ For CONCISE LungScan / ColoScan
10 FFPE unstained coated slides</td><td><u>For all CONCISE tests:</u>
• 5μm thick each
• Surface Area ≥ 20 mm^2
• Tumor Content : ≥ 5%
Pathology report is required.</td></tr>
</table>

Bill to: Codex Genetics Limited, Unit 220, 2/F, Hong Kong Science Park 16W, Shatin, N.T.

For any enquiries, please contact Ms. Sherie Lee (Codex Genetics) at 3008 2560 for specimen collection and logistics.

I, **Dr.** _____*(Dr. Name)*, hereby to confirm that the indicated patient has understood and accepted the recommendation for the genetic testing service, that this specimen retrieval and preparation is medically indicated. I authorize both your laboratory and Codex Genetics to proceed as outlined.

Yours Sincerely,

Clinician Name: **Patient Name:**

Clinician Signature: **Patient Signature:**