PARADIGM REQUISITION Sig 445 North 5th Street, Suite 300 Fac Phoenix, AZ 85004 • 844-232-4719 Init 602-850-7080 Mo Patient Name Last First Patient Address City Policy Holders Name Primary Policy Holders Name Second If patient has Medicare as insurance, please ensure ABN is completed by the consent has been obtained for the test and release of the result of the reimbursement process and for the laboratory to obtain cover and the patient or client receive a bill, please contact ou We may not charge for the difference for the insurance's allowed on the health plan, there may be patient financial responsibility Ordering Physician to be contacted with results and Practice/Institution Name Ordering Maddress City Office Contact Phone Specimen Retrieval Option Unless specified, we will contact the pathology depator to NOT provide this service and your institution will Pathology Information Practice/Institution Name Patholog Practice/Institution Name City Pathology Information Practice/Institution Name Pathology Practice/Institution Name Pathology Pathology Practice/Institution Name Pathology Pathology </th <th>ment cate of Medical Necessity and to the third party payer wher follow-up information. Shour r client services for discounts d amount and the list price all (, including co-payments and (or questions) (See b ang Physician) rtment indicated below t arrange for specimen shi ogist Name</th> <th>be billed. For Med charges must be b MI Primary Po Secondary uisition. I that the patient's necessary as part Id insurance not or payment plans. hough depending I deductibles. ack for additional co State Email o request your pati pping.</th> <th>CD-10 Codes CD-10 Codes CD-10</th> <th>Patient Registration Home Phone # Primary Group # Primary Group # Primary Group # quired for billing. When or pe sought, only order tests regnosis and treatment of th ort distribution) Email Phone Fax</th> <th>his form, your facility will ent on the date of servic or Medical Record # Patient DOB Policy Holders DO Policy Holders DO Policy Holders DO Fax</th>	ment cate of Medical Necessity and to the third party payer wher follow-up information. Shour r client services for discounts d amount and the list price all (, including co-payments and (or questions) (See b ang Physician) rtment indicated below t arrange for specimen shi ogist Name	be billed. For Med charges must be b MI Primary Po Secondary uisition. I that the patient's necessary as part Id insurance not or payment plans. hough depending I deductibles. ack for additional co State Email o request your pati pping.	CD-10 Codes CD-10	Patient Registration Home Phone # Primary Group # Primary Group # Primary Group # quired for billing. When or pe sought, only order tests regnosis and treatment of th ort distribution) Email Phone Fax	his form, your facility will ent on the date of servic or Medical Record # Patient DOB Policy Holders DO Policy Holders DO Policy Holders DO Fax
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Includes NGS Analysis (DNA and RNA) + Tumor Spectrum BREAST: AR, CAIX, hENT1, PD-L1, PTEN, TOPO1, 1	PCDx may change over t current list of biomarkers a	ne course of time. Al analyzed by tumor typ	though we do our be pe.	est to educate our clients c	on any testing changes,
BREAST: AR, CAIX, hENT1, PD-L1, PTEN, TOPO1,	ECK TESTING & REPORTING	OPTION BELOW:			
				rkers are being requested left selected panel please	
COLON: HER2, MGMT, PD-L1, PTEN TOPO1, (Misr					
NOCLO ALIC LENTA MET DD LA DTEN DOCA TO		2, MSH6, PMS2)	□AR		□ROS1 □TRKpan
NCSLC: ALK, hENT1, MET, PD-L1, PTEN, ROS1, TO					
OTHER SOLID TUMORS: CAIX, hENT1, HER2, PD-I	1, ILE3, IOPOT, IP		□ ER		
Include NGS Analysis (DNA and RNA) Only				n Repair (includes 4 IHCs): N	
			□ Pertorm f	full panel of orderable IHC	Biomarkers
Additional Information Priority Turn-Around Second Submission 	Ethnicity (check a		er 🗌 White	🗆 Hispanic	
Associated Study:	🛛 🗆 Alaskan Native	□ Asian	□ Black	•	
Treatment Status/History					
•	ent/Progression/Metasta				
Current Therapy Chemo Radiation Immun First Line Chemo Radiation Immun		5			
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Third Line Chemo Chemo Inadiation Immun	o 🗆 Hormonal 🗆 Tar	•			



PARADIGM CANCER DIAGNOSTIC (PCDX[™]) – SPECIMEN REQUIREMENTS

Formalin Fixed Paraffin Embedded (FFPE) Samples

PCDX™	SAMPLE	SPECIMEN REQUIREMENTS	TUMOR	CONTENT	SAMPI	LE SIZE	
TESTING	TYPE	SPECIMEN REQUIREMENTS	OPTIMAL	MINIMAL	OPTIMAL	MINIMAL	
	Paraffin Block	(1) FFPE block from most recent surgery or biopsy, containing the most amount of tumor, excluding bone.					
NGS Analysis	Shaves/Curls	(6-10) 10 micrometer thick freshly cut curls along with H&E stained section of same block.			75 mm³	One (1) core needle with	
	Slides	(12-20) 4 or 5 micrometer unbaked, unstained slides, or (6-10) 10 micrometer unbaked, unstained slides.	40%	10%*	(5 mm x 5 mm x 3 mm) or	10% tumor (10mm x 2mm x 1mm)	
	Paraffin Block	(1) FFPE block from most recent surgery or biopsy, containing the most amount of tumor, excluding bone.				4 to 6 needle biopsies	* RISK THAT FULL PROFILE CANNOT BE PERFORMED
NGS Analysis & IHC	Shaves/Curls & Unstained Slides	(6-10) 10 micrometer thick freshly cut curls along with H&E stained section of same block & (7-25) 4 micrometer, freshly cut, unstained, unbaked, sections on positively charged slides, or (1) Slide per IHC selected +1					

* PARADIGM CUSTOMER SERVICE WILL CONTACT THE ORDERING PHYSICIAN IF THE SPECIMEN RECEIVED FOR TESTING DOES NOT MEET OUR ESTABLISHED REQUIREMENTS.

Testing Prioritization

In the case where the sample is inadequate to run the entire analysis, the priority of testing will be:

1.) DNA for mutations, copy number variations and chromosomal changes,

2.) RNA for mRNA expression and

3.) Protein by IHC

Additional contacts to rece	ive results and/or questions					
Name	Ordering Physician		NPI#	Email		
Address	City	State	ZIP	Phone	Fax	
Name	Ordering Physician		NPI#	Email		
Address	City	State	ZIP	Phone	Fax	

Exclusions

 \Box Please do not run or report the following genes: