natera™ | ONCOLOGY

Please place Signatera/Altera sample kit barcode here
1234567-2-X SB/ST

Date of Sample Collection (MM/DD/YY)* _____

Please send completed form in sample kit. For Natera-collected samples, email form to oncologyCE@natera.com or fax to +1 (650) 412-1962
(*) denotes required fields. Failure to complete will result in testing delays. | Inquiries: +1 (650) 489-9050

1. PATIENT INFORMATION*

Last Name* | Middle Name* | First Name*

Date of Birth (MM/DD/YY)* | ◯F ◯M Sex Assigned at Birth* | MRN | Last 4 digits of SSN

Email Address | ( ) Cell Phone*

Street Address*

City* | State* | Zip Code*

2. ORDERING CLINICIAN*

Ordering Clinician* | NPI Number

(Natera Account ID) Clinic or Organization*

Street Address* | City* | State* | Zip Code*

( ) Telephone Number* | Clinic or Organization Fax or Email*

Additional Report Recipient | Additional Report Recipient Fax or Email

STATEMENT OF MEDICAL NECESSITY I confirm the testing ordered herein is medically necessary and this patient has been informed of the details of the genetic test(s) ordered, including the risks, benefits, and alternatives, and has consented to testing as may be required by law, including NY CVR §79-l, as applicable. I authorize the referral of this patient to a third-party genetic counseling service if required by the patient's insurance provider.

I hereby authorize the pathology laboratory to release the patient's specimen to Natera.

Ordering Clinician / Authorized Signature* | Date*

3. TEST ORDER SELECTION*

SIGNATERA
Molecular Residual Disease (MRD)

*Must select **only one** testing cadence below:*

◯ 4 weeks
◯ 6 weeks
◯ 8 weeks
Please indicate the total number of desired draws: _____
If left blank, order will default to 12 months of draws
◯ 3 months
◯ 6 months
◯ Single test order
◯ MRD & Recurrence Monitoring recommended cadence

See back for cadence schedule & additional test details

ALTERA
Tissue Comprehensive Genomic Profiling (CGP)

◯ Whole Exome DNA (inclusive of MSI and TMB) + Whole Transcriptome RNA Sequencing

- *Available for Active Stage III / IV / Recurrent only.*
- *If ordered with an initial Signatera test, Altera can be run using the same tissue and blood samples.*
- *If Signatera has been previously ordered for this patient, additional blood and tissue samples are required.*
- *Not available for samples collected in NY State.*

EMPOWER
Germline Hereditary Cancer

*Must select **only one** base test below:*

◯ *BRCA1 & BRCA2*
◯ Lynch Syndrome *(MLH1, MSH2, MSH6, PMS2, EPCAM)*
◯ Other Panel ID _____

May select only one additional test (optional):

◯ Multi-Cancer (40 genes total)
◯ Comprehensive (81 genes total)

Must complete "Empower Information" section on back AND collect Empower EDTA tube in Signatera/Altera blood kit.

4. SIGNATERA & ALTERA CLINICAL INFORMATION

Cancer type to be tested for Signatera/Altera:* *(select one cancer type)*

◯ Colorectal ◯ Bladder ◯ Breast ◯ Lung ◯ Melanoma ◯ Other _____ Date of diagnosis (MM/DD/YY) _____

Subtype _____ Stage:* ◯ I ◯ II ◯ III ◯ IV ◯ Other _____ Date of curative intent surgery* _____

Is patient receiving or planning to receive immunotherapy?* ◯ Yes ◯ No ◯ Unknown
please enter drug name(s) _____

History of recurrence? ◯ Yes ◯ No

Active disease? ◯ Yes ◯ No Evidence of Disease

ICD-10 CODES*

Enter relevant codes for each test

Signatera & Altera

Empower

For codes, visit: natera.com/icd10codes

5. SPECIMEN COLLECTION & RETRIEVAL – *Initial Order*

Blood draw(s) to be managed by: ◯ Natera Mobile Phlebotomy (default) ◯ Clinic OR ◯ Clinic managed for first draw, Natera managed for subsequent draws
Tissue acquisition to be managed by: ◯ Natera (default) OR ◯ Clinic will coordinate shipping of sample to Natera. Notes: _____

◯ **Most recent progress/clinical note attached***
◯ **Pathology report attached***
Tissue acquisition cannot occur without a pathology report

Tissue Collection Date (MM/DD/YY)

Accession # / Block ID #
Please see instructions in kit for details

Pathology Lab Name / Contact* | Address

City | State | Zip

( ) Phone* | Fax* | Email

6. INSURANCE & PAYMENT INFORMATION

Please attach front and back of insurance card. **Medicare only – Patient Status:** ◯ If inpatient, add Date of Discharge _____ ◯ Outpatient

Bill To:* ◯ Medicare ◯ Self-pay ◯ Other Insurance ◯ Clinic

Insurance Company* | Member ID* | Group Number | Prior Authorization Number

7. PATIENT ACKNOWLEDGMENT

By my signature I acknowledge that I have read and agreed to the following and to the Patient Acknowledgment for testing on the back page.

New York residents must check this box ☐ and sign below to permit Natera to use their samples for research and development; otherwise, their samples will be discarded within 60 days of testing.

I understand that my/my child's treatment, payment, enrollment, or eligibility for benefits is not conditioned on my providing such consent, and I may opt out at any time or by checking this box ☐.

I hereby authorize Natera, Inc. to obtain my/my child's pathology specimens.

Patient/Guardian Signature* | Date*

By providing the information included herein, I understand and agree I may be contacted by email, cell, home phone, text message, automatic telephone dialing system, or computer assisted technology for treatment options, billing/collection matters, and health-related products, services, or studies.

CONTRAINDICATIONS

Signatera testing: Patients with a history of allogenic bone marrow transplant, ***OR*** have had blood transfusions within the last three months
Empower testing: Patients with a history of allogenic bone marrow transplant, ***OR*** have current or previous history of hematologic malignancy

BLOOD DRAW MANAGEMENT

Natera Managed: For Natera managed draws, our Patient Coordinators will contact the patient directly and schedule a time for a Mobile Phlebotomy Specialist to draw the sample at the patient's convenience. The sample collection kit, along with a pre-filled order form, will be shipped to the patient prior to their schedule draw.

Clinic Managed: For clinic managed draws, you are indicating that the patient's blood sample will be collected and sent by your clinic to Natera. A sample collection kit, along with a pre-filled order form, will be shipped directly to the patient to bring into the clinic, unless otherwise indicated.

SAMPLE REQUIREMENTS

Submission Checklist: 1) Signed order form 2) Pathology Report 3) Most recent progress/clinical note 4) Copy of insurance card

Sample Type	Initial Signatera order +/- Altera	Signatera subsequent orders	Altera only	Empower *(include additional Empower-labeled EDTA tube)*
Tumor Tissue w/Pathology Report	✓		✓	
EDTA | Whole Blood (6mL K2 or K3)	✓		✓	✓
2x Streck | Plasma (10mL Tiger Top)	✓	✓		

8. EMPOWER INFORMATION*

PATIENT COMPLETE CANCER HISTORY *(include all cancers and age of dx)*

○ No personal history of cancer
○ Patient has had genetic testing for hereditary cancer (If yes, please attach the report)

Cancer/Tumor	Age at Dx
○ Breast ○ Invasive Ductal ○ DCIS ○ Invasive Lobular ○ Triple negative (ER-, PR-, HER2-) ○ High-Risk HER2-** ○ Metastatic	
○ Ovarian ○ Non-epithelial	
○ Prostate ○ Metastatic ○ Intraductal/Cribriform	
○ Pancreatic	
○ Endometrial/Uterine	
○ Colon/Rectal	
○ Stomach	
○ Other cancer(s): Type _____	

Additional information
○ Colon Polyps: Number of polyps _____
If tumor screening was performed, select all that apply:
○ MSI high? If yes, cancer type tested _____
○ Mismatch Repair (MMR) proteins absent on IHC? Result _____

** See NCCN.org for the definition of high-risk disease

FAMILY HISTORY OF CANCER

○ No known family history
○ Limited family structure: Adopted or less than two 1st/2nd degree relatives living past age 45 years old
○ Check this box if any below relatives are willing to be tested

Relationship	Maternal or Paternal		Cancer site(s)	Age at Dx	Relative Deceased
	○	○			○
	○	○			○
	○	○			○
	○	○			○
	○	○			○
	○	○			○

Additional information

Known Familial Mutation: Gene: _____ Variant: _____
Relationship _____ Report available? ○ Yes (please attach) ○ No

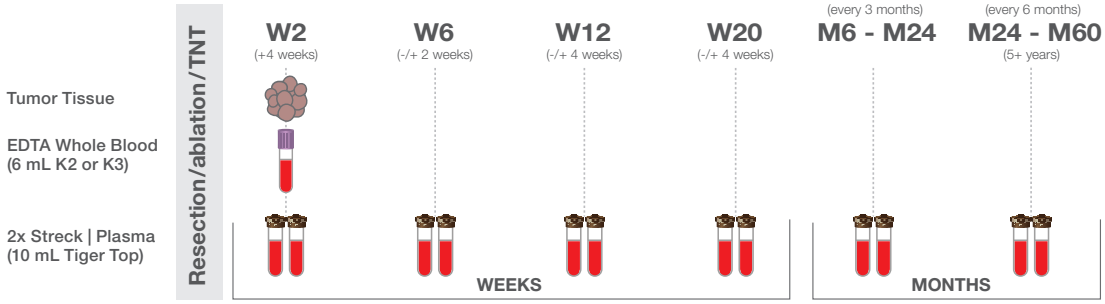
Race or ethnicity

○ African American/Black
○ American Indian or Alaska Native
○ Ashkenazi Jewish
○ East Asian
○ Hispanic/Latin American
○ Native Hawaiian or other Pacific Islander
○ South Asian
○ Southeast Asian
○ White (Non-Hispanic)
○ Other _____

For the full list of genes in each Empower test, visit https://www.natera.com/empower-for-clinicians/

If you're looking for the Breast STAT test, breast cancer risk model or the family testing program, please see the Empower only test requisition or order online at oncology.natera.com

SIGNATERA MRD & RECURRENCE MONITORING RECOMMENDED CADENCE DRAW SCHEDULE



MRD & Recurrence monitoring cadence requires the **date of curative intent surgery.** This cadence is available for all solid tumor histologies, and ctDNA assessment may begin BEFORE surgery, to help evaluate the effectiveness of neoadjuvant therapy and/or surgical intervention.

MRD & Recurrence Monitoring Recommended Cadence order directs Natera to:

1. When date of surgery is known (either previous or upcoming surgery date), Natera to arrange pre-surgical blood draws every 4 weeks and post-surgical blood draws that approximate the schedule illustrated above.
2. If no surgery date is provided, patient will be defaulted to a 3 month schedule.

Note: Schedules may be adjusted at any time by the ordering provider, via email to **OncologyCE@natera.com** or by calling **650.489.9050**.
Recurring orders expire 12 months from date of signature

PATIENT ACKNOWLEDGMENT (READ AND SIGN THE FRONT OF THIS PAGE)

I have been informed of and understand the details of the test ordered herein for me by my/my child's health care provider, including the risks, benefits, and alternatives, and have consented to testing. I understand that the test results may inform me of a medical condition that may require medical follow-up. I also understand that a negative result does not rule out the possibility of such medical condition. I authorize Natera or other provider to share the information on this form and my/my child's test results with my/my child's insurer/health plan ("plan") on my/my child's behalf, with all benefits of my/my child's plan made payable directly to Natera or other provider. I understand that I am responsible for (a) costs not paid by my/my child's plan directly to Natera for tests ordered, including, without limitation, any copayments, deductibles, or amounts deemed 'patient responsibility' and (b) any amounts paid to me by my/my child's plan. This testing will not be covered by my/my child's plan if it is outside of the plan's coverage guidelines or deemed not medically necessary – (e.g. where prior authorization is required but not obtained) and I will be responsible for the cost of such testing. I assign to Natera the right to appeal on my/my child's behalf negative coverage decisions made by my/my child's plan and to assert all rights and claims reserved to me/my child as the beneficiary thereof. The information obtained from my/my child's tests may be used in scientific research, publications or presentations, but my/my child's specific identity will not be revealed. Natera may contact my/my child's healthcare provider to obtain more information regarding clinical correlation and confirmatory testing. My/my child's leftover samples may be de-identified, including those specimens obtained from other institutions with my consent, and used for research and development. I and my heirs will not receive payments, benefits, or rights to any resulting products or discoveries. If I do not want my/my child's samples used for research and development purposes, I will send a request in writing to Natera Sample Retention Department at the address on page 1 within 60 days after test results have been issued and my/my child's samples will be destroyed.