# elive™ Test Order Form

**Early Access Program**

Elephas Laboratories Customer Support
Phone: (608) 622 - 7642 | Fax: (855) 350 - 1433 | Email: elive@elephaslabs.com

elephas LABORATORIES

Please send the completed form via email to elive@elephaslabs.com or via fax at (855) 350 - 1433. Elephas will ensure that a sample collection kit is available at the facility responsible for collecting the biopsy. Failure to provide complete information may result in test delays.

## Section 1: Test Information

☑ **elive Test**, cytokine response profile of ex vivo tumor biopsy to anti-PD-1 biosimilar

## Section 2: Provider Information

Physician First Name _____ Physician Last Name _____ NPI _____

Physician Phone Number _____ Physician Email _____

Institution Name _____ Institution Address _____ Institution City _____ State _____ Zip _____

Office Contact Name _____ Office Contact Phone Number _____ Office Contact Email _____

## Section 3: Patient Information

First Name _____ Last Name _____ Date of Birth (MM/DD/YYYY) ___/___/___ ☐ F ☐ M Sex at Birth Medical Record Number _____

**Tumor Type**

☐ Suspected ☐ Confirmed

**Suspected Stage**

☐ Early (I / II) ☐ Advanced/Metastatic (III / IV) ☐ Recurrent

**Primary Tumor Type**

☐ Bladder ☐ Endometrial ☐ Liver ☐ Skin – Basal Cell Carcinoma ☐ Other (please specifiy): _____

☐ Breast - TNBC ☐ Head and Neck ☐ Lung - NSCLC ☐ Skin – Cutaneous Squamous Cell Carcinoma

☐ Colorectal - dMMR ☐ Kidney ☐ Melanoma

**Planned Treatment Regimen**

☐ Pembrolizumab monotherapy ☐ Nivolumab + Ipilimumab ☐ Nivolumab + Relatlimab

☐ Nivolumab monotherapy ☐ Atezolizumab monotherapy ☐ Durvalumab + Tremelimumab

☐ Durvalumab monotherapy ☐ Other (please specifiy): _____

## Section 4: Biopsy Information

Institution Name _____ Institution Address _____ Institution City _____ State _____ Zip _____

Institution Phone Number _____

Select one: ☐ Biopsy Order Date ___/___/___ (MM/DD/YYYY) OR ☐ Biopsy Scheduled Date ___/___/___ (MM/DD/YYYY)

## Section 5: Certification by Ordering Physician

I certify that I am ordering this test for Early Access Program purposes in compliance with applicable law and that appropriate patient consent has been obtained. I agree that Elephas Laboratories may request limited follow-up information, consistent with HIPAA and other applicable privacy laws, for quality assessment and improvement, limited to the minimum necessary and including de-identified or limited datasets as permitted by law. I will not share the RUO Report or test results with the patient, use the results for clinical decision-making, or include them in the patient's medical record. I will not seek reimbursement for this test from any third party, including federal health care programs, and will comply with applicable privacy laws. I understand that this test does not create any obligation or inducement to use or promote any Elephas Laboratories product or service. By submitting this form, I agree to Elephas Laboratories' Terms of Service at www.elephaslabs.com.

Phyician Signature _____ ___/___/___ (MM/DD/YYYY)