elive™ Test Order Form

Elephas Laboratories Customer Support
Phone: (608) 292-7642
Fax: (855) 350-1433
Email: elive@elephaslabs.com

Please send the completed form via secure 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

Profile Selection

Select only one. If no selection is made, the lab will default to aPD-1.

◯ aPD-1 ◯ aPD-1 + aCTLA-4

◯ aPD-L1 ◯ aPD-L1 + aCTLA-4

Section 2: Ordering Physician 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

Patient First Name _____ Patient Last Name _____ Medical Record Number _____

__/__/____ Date of Birth MM/DD/YYYY

☐ F ☐ M Sex at Birth

Tumor Type

☐ Suspected ☐ Confirmed

Patient Phone Number _____ Patient Address _____ City _____ State _____ Zip _____

Suspected Stage

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

Primary Tumor Type

☐ Bladder ☐ Endometrial ☐ Liver ☐ Skin – Basal Cell Carcinoma

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

☐ Colorectal - dMMR ☐ Kidney ☐ Melanoma ☐ Other (please specifiy):

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Section 4: Billing Information

4A: Diagnosis Code

If patient is self-pay, skip to section 5

_____ ☐ Patient is self-pay

ICD-10 Diagnosis Code

4B: Insurance / Payor

☐ Medicare ☐ Private Insurance

_____ _____ _____

Payor Name | Policy / Member Number | Group Number

4C: Subscriber / Guarantor

Relationship to Patient:

◯ Self ◯ Spouse ◯ Child ◯ Other

If "self" is selected, skip the fields below.

_____ _____ ___/___/___ _____

Subscriber First Name | Subscriber Last Name | Subscriber Date of Birth MM/DD/YYYY | Subscriber Member ID

_____ _____ _____ _____

Subscriber Address | City | State | Zip

4D: Hospital Status at the Time of Collection

Required for Medicare

◯ Outpatient ◯ Non-Hospital / Office ◯ Hospital Inpatient

Section 5: Biopsy Information

_____ _____ _____ _____ _____

Institution Name | Institution Address | City | State | Zip

_____ Select one: ☐ Biopsy Order Date OR ☐ Biopsy Scheduled Date ___/___/___

Institution Phone Number MM/DD/YYYY

Section 6: Certification by Ordering Physician

As the patient's treating physician, I have concluded that the test I am ordering is medically necessary for treatment of this patient. I anticipate that this test will provide prognostic and/or predictive information which has not been obtained already. I confirm the patient consented for this test to be performed for this purpose, and for the test to be administered and billed by Elephas (or its affiliates), and, if applicable, for the patient's medical information (including the test results) to be exchanged between myself and Elephas for treatment and payment purposes. This Test Order Form: (i) is part of the patient's medical record and consistent with other entries in the record; (ii) contains complete and correct information; and (iii) accurately describes the reason(s) I am ordering the test. I acknowledge that Elephas may contact me to request follow-up information pertaining to this patient after the test is completed, as permitted by the HIPAA Rules, for the purpose of conducting quality assessment and improvement activities related to the test.

_____ ___/___/___

Physician Signature MM/DD/YYYY