AR-V7 by Epic Sciences
Tel. 1.800.941.0522

AR-V7 by epic sciences
THE POWER OF CLARITY™

Complete and return with collection kit

TEST ORDERED

☐ AR-V7 by Epic Sciences

PATIENT INFORMATION

Patient Name (Last, First, MI)

DOB (mm/dd/yyyy) ☐ Male ☐ Female

Medical Record or Patient # (if applicable)

Address

City State Zip Country

Primary Phone Alternate Phone (optional)

DIAGNOSIS INFORMATION (complete all)

Metastatic (stage IV), castration-resistant prostate cancer (at last visit):

☐ Yes ☐ No

Intended use: The AR-V7 by Epic Sciences test is intended for use in patients with metastatic castration-resistant prostate cancer (mCRPC) who are considering androgen receptor signaling inhibitors.

Patient received and failed either Enzalutamide (Xtandi), Apultamide (Erleada), Abiraterone (Zytiga), or Darolutamide (Nubeqa): ☐ Yes ☐ No

Has the patient demonstrated one of the following signs of disease progression:

- **Rising PSA levels 1 or more weeks apart?** ☐ Yes ☐ No
- **New or enlarged lesions detected radiologically?** ☐ Yes ☐ No

ICD-10 Code:

☐ C61 (Malignant neoplasm of prostate)

☐ Other

ORDERING INFORMATION

Practice Account Name Account #

Ordering Physician Name Fax# Email

Address City State Zip

Contact Name Contact Phone

Additional Physician/Report Recipient (optional)

Email

Phone Fax#

BILLING INFORMATION

Select Billing Type

☐ Commercial Insurance ☐ Patient
☐ Medicare ☐ Contracted Account
☐ Medicaid

Hospital Status at Time of Specimen Collection (Medicare only)

☐ Non-hospital Patient
☐ Hospital Outpatient
☐ Hospital Inpatient (>24 hour stay)

Primary Insurance Company Name Member ID# Prior Authorization# (if applicable)

Secondary Insurance Company Name (if applicable) Member ID# Prior Authorization# (if applicable)

PHYSICIAN SIGNATURE & ATTESTATION

By signing I certify the following: 1) this test is medically necessary and the results will be used with other clinical data to help determine the appropriate treatment plan for the patient, 2) the patient has been informed of the benefits, risks, and limitations of the tests requested as well as the availability of genetic counseling, and 3) I have obtained informed consent from the patient for the test(s) requested.

If available, please include a copy of:

☐ Front and back of insurance card
☐ Physician's recent clinical note

Exception Criteria/Comments

Ordering Physician Signature Print Physician Name Date (mm/dd/yyyy)

PATIENT SIGNATURE & ATTESTATION

I consent to Epic Sciences, Inc. ("Epic") performing the test(s) on my blood sample that were ordered by my healthcare provider. I consent to Epic contacting me directly at the email and phone number provided on this form. I acknowledge that Epic's tests do not provide a medical diagnosis nor specific treatment recommendations and only provide information for my physician's review and consideration along with other information relevant to treatment decisions.

Patient Signature Print Patient Name Date (mm/dd/yyyy)

LABORATORY/PHLEBOTOMIST TO COMPLETE - No substitutions for this assay

Laboratory/Phlebotomist Account Name

Laboratory/Phlebotomist Contact Name

Phone

Specimen ID (if applicable)

Date of Collection (mm/dd/yyyy)

Draw Site Zip Code

Specimen Type:
☐ Peripheral Blood

☐ AM ☐ PM

Time of Collection

Affix the bar-code from the specimen collection kit in this location

MKT-PN-LBL-00052
Rev 1

Laboratory Comments: