eLIVE™ Test Order Form

Early Access Program - For Research Use Only

Elephas Laboratories Customer Support
Phone: (608) 622 - 7954
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 Laboratories 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 Ordered

☐ **Elephas Laboratories eLIVE test**, cytokine response profile of ex vivo tumor biopsy to anti-PD-1 biosimilar

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

First Name _____ Last Name _____ Date of Birth ___/___/_____ ☐ 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
☐ Breast – TNBC
☐ Colorectal – dMMR
☐ Endometrial
☐ Head and Neck
☐ Kidney
☐ Liver
☐ Lung - NSCLC
☐ Melanoma
☐ Skin – Basal Cell Carcinoma
☐ Skin – Cutaneous Squamous Cell Carcinoma
☐ Other (please specify): _____

Primary Treatment Regimen

☐ Pembrolizumab monotherapy
☐ Nivolumab monotherapy
☐ Durvalumab monotherapy
☐ Nivolumab + Ipilimumab
☐ Atezolizumab monotherapy
☐ Other (please specify): _____
☐ Nivolumab + Relatlimab
☐ Durvalumab + Tremelimumab

Section 4: Biopsy Information

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

Institution Phone Number _____

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

Section 5: Certification by Ordering Physician

I certify that I have obtained the patient's consent and authorization for Elephas Laboratories to perform this test for research purposes and to exchange the patient's medical information for purposes of this research, including follow-up information after the test is completed, as applicable, as part of this research. I agree to provide a copy of the patient's signed consent and authorization forms to Elephas Laboratories upon request. I acknowledge this test is for research purposes only, and I will not rely on the test results for clinical purposes or enter the results into the patient's medical record. I agree that I will not seek reimbursement for this test from any third party, including but not limited to federal health care programs. I understand that the use of this test is not intended to be, nor should it be construed as, an express or implied obligation or inducement for me to recommend, purchase, order, prescribe, administer or otherwise promote any Elephas Laboratories product or service. In submitting this EAP Test Order Form, I acknowledge that I have read and agree to be bound by Elephas Laboratories' General Terms of Service found at www.elephaslabs.com

_____ _____

Physician Signature Date