Ordering a Galleri™ test

How to order the Galleri test using the paper Test Requisition Form (TRF)

Completion of all fields on the TRF is required for specimen processing and reporting of test results.

1 Patient information

Write the patient's full legal name, sex, date of birth, street address, contact information, and medical record number (MRN) or other ID. The patient's sex should reflect their chromosomal makeup, rather than their gender identity.

2 Sending test kits to an alternate address

If preferred, the specimen collection kit can be sent directly to the patient or to an alternate address. Check the corresponding box and write in the address. Fax the completed requisition form to (650-999-9000).

3 Clinical information

Check the box in the Test Requested field to order the Galleri test. If the patient has had a transplant, or is currently pregnant, check the corresponding box. This information may help explain unexpected chromosomal findings. Provide any ICD-10 codes that demonstrate medical necessity for the Galleri test, and the patient's clinical history.

4 Provider information

Write your assigned account ID, followed by the organization that the ordering provider's office is affiliated with. Enter the office location name that the ordering provider is affiliated with. Fill in the ordering provider's office contact information.

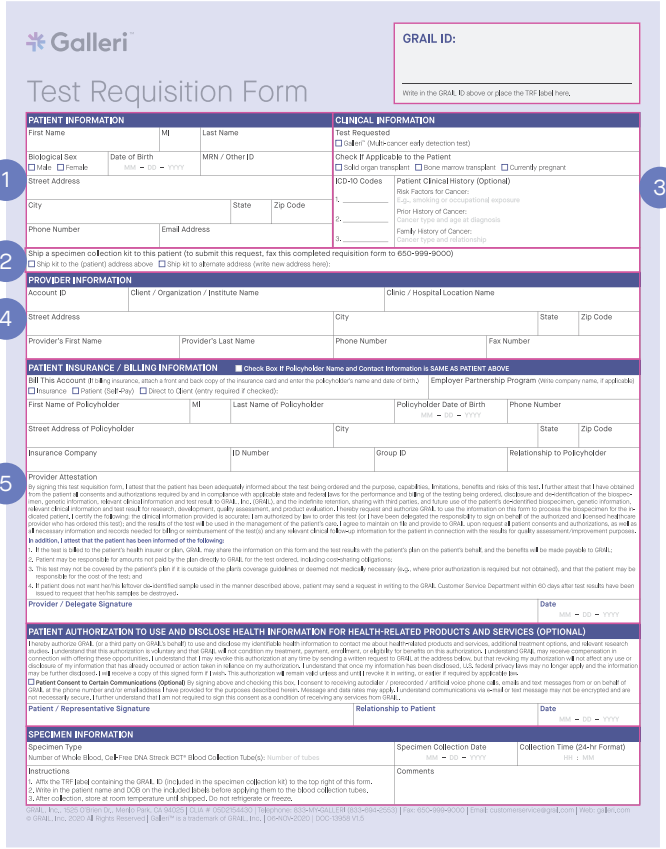
5 Patient insurance / billing information

Insurance billing is available only through predetermined agreements with GRAIL. If the patient has consented to pay GRAIL directly for the test, check the box next to Patient (Self-Pay). If you have a contracted client billing agreement with GRAIL, check the box next to "Direct to Client." Then write in the name listed in the Provider Information section under the Client / Organization / Institute field.

A. If the selected bill type is "Insurance," please submit a front and back copy of the patient's insurance card with the TRF.

B. If the selected bill type is "Direct to Client" or "Patient (Self-Pay)," the rest of the billing information section does not need to be completed.

C. If the patient is receiving the Galleri test as a benefit through the GRAIL Employer Partnership Program, write the name of the employer in the "Employer Partnership Program" field.



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6 Optional patient acknowledgment

Provide the TRF to the patient to read, and ask the patient if they would like to sign the acknowledgment. The patient's or patient's representative's signature and date in this optional section authorizes GRAIL to use personal information for the additional specified purposes. Patient provision of this authorization is voluntary. Payment for treatment, health insurance, and eligibility will not be affected if the patient does not sign this section, nor will the patient receive additional compensation for signing this acknowledgment.

7 Specimen information

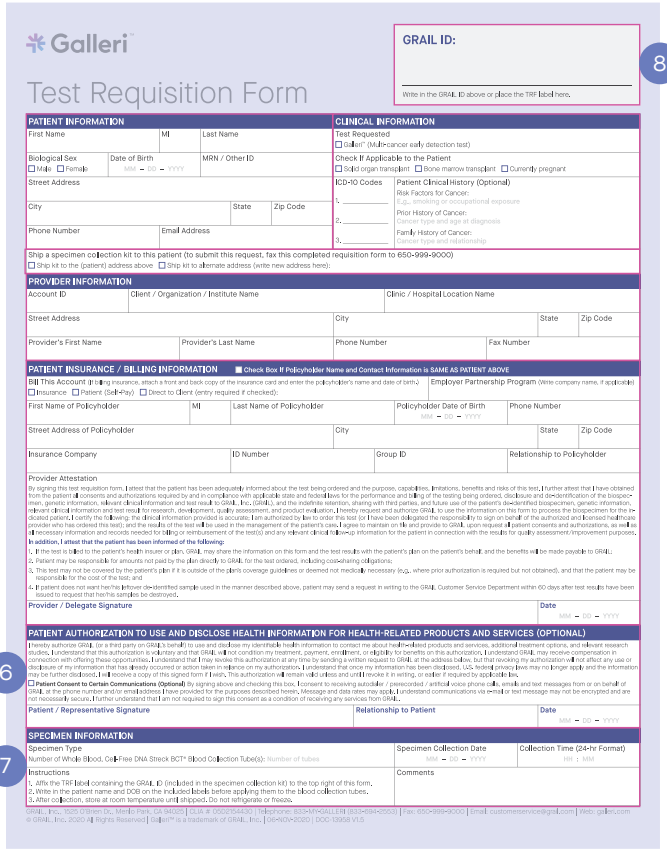
Two (2) Cell-Free DNA Streck BCT® tubes containing 10 mL of whole blood should be submitted for the Galleri test. Record the date and time that the patient's sample was collected and any additional comments if needed.

8 GRAIL ID

Record the GRAIL ID in the top right corner of the TRF by affixing the TRF label included on the Label Page in the document pouch of the Galleri specimen collection kit, or write in the GRAIL ID. The GRAIL ID is a single 10-digit alphanumeric identifier located on the tube labels and specimen collection kit.

Next steps

Record the GRAIL ID in the top right corner of the TRF by affixing the TRF label included on the Label Page in the document pouch of the Galleri specimen collection kit, or write in the GRAIL ID. The GRAIL ID is a single 10-digit alphanumeric identifier located on the tube labels and specimen collection kit.


Galleri

Test Requisition Form

GRAIL ID:

Write in the GRAIL ID above or place the TRF label here.

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PATIENT INFORMATION

First Name | MI | Last Name

Biological Sex ☐ Male ☐ Female | Date of Birth MM – DD – YYYY | MRN / Other ID

Street Address

City | State | Zip Code

Phone Number | Email Address

CLINICAL INFORMATION

Test Requested ☐ Galleri® (Multi-cancer early detection test)

Check If Applicable to the Patient ☐ Solid organ transplant ☐ Bone marrow transplant ☐ Currently pregnant

ICD-10 Codes 1. 2. 3.

Patient Clinical History (Optional)

Risk Factors for Cancer: e.g., smoking or occupational exposure

Prior History of Cancer: Cancer type and age at diagnosis

Family History of Cancer: Cancer type and relationship

Ship a specimen collection kit to this patient (to submit this request, fax this completed requisition form to 650-999-9000)

☐ Ship kit to the (patient) address above ☐ Ship kit to alternate address (write new address here):

PROVIDER INFORMATION

Account ID | Client / Organization / Institute Name | Clinic / Hospital Location Name

Street Address | City | State | Zip Code

Provider's First Name | Provider's Last Name | Phone Number | Fax Number

PATIENT INSURANCE / BILLING INFORMATION ■ Check Box If Policyholder Name and Contact Information is SAME AS PATIENT ABOVE

Bill This Account (if using insurance, attach a front and back copy of the insurance card and enter the policyholder's name and date of birth.) | Employer Partnership Program (Write company name, if applicable)

☐ Insurance ☐ Patient (Self-Pay) ☐ Direct to Client (entry required if checked):

First Name of Policyholder | MI | Last Name of Policyholder | Policyholder Date of Birth MM – DD – YYYY | Phone Number

Street Address of Policyholder | City | State | Zip Code

Insurance Company | ID Number | Group ID | Relationship to Policyholder

Provider Attestation

By signing this test requisition form, I attest that the patient has been adequately informed about the test being ordered and the purpose, capabilities, limitations, benefits and risks of this test. I further attest that I have obtained from the patient all consents and authorizations required by and in compliance with applicable state and federal laws for the performance and billing of the testing being ordered, disclosure and de-identification of the biospecimen, genetic information, relevant clinical information and test result to GRAIL, Inc. (GRAIL), and the indefinite retention, sharing with third parties, and future use of the patient's de-identified biospecimen, genetic information, relevant clinical information and test result for research, development, quality assessment, and product evaluation. I hereby request and authorize GRAIL to use the information on this form to process the biospecimen for the indicated patient. I certify the following: the clinical information provided is accurate; I am authorized by law to order this test (or I have been delegated the responsibility to sign on behalf of the authorized and licensed healthcare provider who has ordered this test); and the results of the test will be used in the management of the patient's care. I agree to maintain an file and provide to GRAIL upon request all patient consents and authorizations, as well as all necessary information and records needed for billing or reimbursement of the test(s) and any relevant clinical follow-up information for the patient in connection with the results for quality assessment/improvement purposes.

In addition, I attest that the patient has been informed of the following:

1. If the test is billed to the patient's health insurer or plan, GRAIL may share the information on this form and the test results with the patient's plan on the patient's behalf, and the benefits will be made payable to GRAIL;
2. Patient may be responsible for amounts not paid by the plan directly to GRAIL for the test ordered, including cost-sharing obligations;
3. This test may not be covered by the patient'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 that the patient may be responsible for the cost of the test; and
4. If patient does not want her/his leftover de-identified sample used in the manner described above, patient may send a request in writing to the GRAIL Customer Service Department within 60 days after test results have been issued to request that her/his sample be destroyed.

Provider / Delegate Signature | Date MM – DD – YYYY

PATIENT AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION FOR HEALTH-RELATED PRODUCTS AND SERVICES (OPTIONAL)

6

I hereby authorize GRAIL (or a third party on GRAIL's behalf) to use and disclose my identifiable health information to contact me about health-related products and services, additional treatment options, and relevant research studies. I understand that this authorization is voluntary and that GRAIL will not condition my treatment, payment, enrollment, or eligibility for benefits on this authorization. I understand GRAIL may receive compensation in connection with offering these opportunities. I understand that I may revoke this authorization at any time by sending a written request to GRAIL at the address below, but that revoking my authorization will not affect any use or disclosure of my information that has already occurred or action taken in reliance on my authorization. I understand that once my information has been disclosed, U.S. federal privacy laws may no longer apply and the information may be further disclosed, but I receive a copy of this signed form if I wish. This authorization will remain valid unless and until I revoke it in writing, or earlier if required by applicable law.

☐ **Patient Consent to Certain Communications (Optional)** By signing above and checking this box, I consent to receiving autodialer / prerecorded / artificial voice phone calls, emails and text messages from or on behalf of GRAIL at the phone number and/or email address I have provided for the purposes described herein. Message and data rates may apply. I understand communications via e-mail or text message may not be encrypted and are not necessarily secure. I further understand that I am not required to sign this consent as a condition of receiving any services from GRAIL.

Patient / Representative Signature | Relationship to Patient | Date MM – DD – YYYY

SPECIMEN INFORMATION

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Specimen Type

Number of Whole Blood, Cell-Free DNA Streck BCT® Blood Collection Tube(s): Number of tubes

Specimen Collection Date MM – DD – YYYY | Collection Time (24-hr Format) HH : MM

Instructions

1. Affix the TRF label containing the GRAIL ID (included in the specimen collection kit) to the top right of this form.
2. Write in the patient name and DOB on the included labels before applying them to the blood collection tubes.
3. After collection, store at room temperature until shipped. Do not refrigerate or freeze.

Comments

GRAIL, Inc., 1525 O'Brien Dr., Menlo Park, CA 94025 | CLIA # 05D2154430 | Telephone: 833-MY-GALLERI (833-694-2553) | Fax: 650-999-9000 | Email: customerservice@grail.com | Web: galleri.com

Contact GRAIL Customer Service at:

Phone
833-MY-GALLERI (833-694-2553)

Email
customerservice@grail.com

Address
1525 O'Brien Drive, Menlo Park, CA 94025

Website
Galleri.com