

*Indicates a required field (these sections to be filled out by the ordering provider's office)

Patient Information

FIRST NAME*	LAST NAME*	DATE OF BIRTH*
ETHNICITY		
<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other		

Ordering Provider Information

FIRST NAME*	LAST NAME*	NPI*	CLINIC / HOSPITAL NAME*
PHONE NUMBER*	FAX*	EMAIL ADDRESS*	
OFFICE CONTACT FIRST NAME	OFFICE CONTACT LAST NAME	OFFICE CONTACT EMAIL ADDRESS	

Clinical Information

TUMOR SIZE MEASURED AT LARGEST DIMENSION (MM)*	AGE*
PATHOLOGICAL NODAL STATUS*	
<input type="checkbox"/> N0 <input type="checkbox"/> N1 (1-3 positive nodes)	

Additional Information (the following must be attached)*

<input type="checkbox"/> Demographic / Face Sheet <input type="checkbox"/> Pathology Report

Test Selection

<input type="checkbox"/> ArteraAI Breast Cancer Test
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Ordering Provider Signature and Attestation

I am the patient's treating physician, and my signature certifies that the clinical information entered on this form is accurate and that this test is medically necessary. I have determined that the patient meets all applicable eligibility criteria for the test; I will use the results to inform my treatment decisions and medical management for this patient. Specifically, the ArteraAI Breast Cancer Test results, in conjunction with other clinical or relevant information, will be used to inform my judgment when determining the appropriateness and intensity of systemic therapy options (eg, chemotherapy, endocrine therapy). By signing this form, I attest that the patient's life expectancy is long enough to consider treatment for breast cancer. I also confirm that the patient is able to tolerate systemic treatment for breast cancer. I understand that the ArteraAI Breast Cancer Test has not been reviewed by the FDA. I hereby authorize testing and confirm that I have obtained informed consent from the patient, to the extent required by law, to proceed with testing, and for Artera Inc. (and its affiliates) to release patient information for claims processing when necessary to obtain reimbursement for this service.

ORDERING PROVIDER SIGNATURE*	DATE*

Specimen Information and Order Acceptance Criteria

The ArteraAI Breast Cancer Test result is dependent on a breast tumor resection specimen as documented in the referring laboratory pathology report. Patient H&E slide(s) OR block(s) are accepted. Please see below for detailed acceptance criteria:

If shipping slides:

- a. Please send one (1) H&E slide containing one (1) surgical specimen of the tumor used by the pathologist in making his or her diagnosis for the patient.

If shipping blocks:

- a. Please send one (1) block containing one (1) surgical specimen of the tumor used by the pathologist in making his or her diagnosis for the patient.

Shipping Instructions

Detailed shipping instructions can be found on the "Pathology Laboratory Instructions" document included in the ArteraAI Breast Cancer Test Kit.

..... ▼ **PATHOLOGY LAB ONLY** ▼

Pathology Lab Information

LAB NAME			STREET ADDRESS		
CITY	STATE	ZIP CODE	PHONE NUMBER	FAX	EMAIL ADDRESS

SPECIMEN INFORMATION (this section to be filled out by the pathology laboratory)

Please send one (1) H&E slide or one (1) block containing one (1) surgical specimen of the tumor used by the pathologist in making his or her diagnosis for the patient.

DATE OF PROCEDURE*	SPECIMEN ID*	NUMBER OF SLIDES / BLOCKS*