

Dear Patient,

This information packet is intended to answer your questions about all Helomics testing, including the Chemosensitivity testing (ChemoFx[®]) and how the tests can benefit you. The packet will also ensure that all of the necessary forms are submitted properly.

Your medical team will send a sample of your tumor to Helomics after your upcoming surgery. In order to initiate testing and provide a final report, your team must submit the following forms:

- A signed Helomics Patient Authorization and Consent Form**

MEDICARE PATIENTS ONLY
Service: ChemoFx Testing

- A signed ABN (Advance Beneficiary Notice of Noncoverage Form)**

The Helomics Universal Informed Consent allows Helomics to complete insurance appeals on your behalf, so you can focus on recovery. Your signed consent not only protects you, but it also protects our clinical colleagues and facilities and may enable your tumor sample to further cancer research and benefit future patients.

After Helomics pursues all appeals on your behalf, and if your insurance continues to deny coverage, you may receive a bill for the applicable copays, deductibles, and coinsurance associated with the cost of testing. Included in this packet (and available upon request) is an application for Helomics' **Compassionate Care** program. Helomics has also recently restructured pricing for ChemoFx testing at a drastically reduced rate, while maintaining the same high-quality standards of testing: \$450 (culture and first unit of drug tested), plus \$15 for each additional drug/drug combo tested. This now makes it more affordable for patients whose insurance denies coverage.

Thank you for your prompt submission of the required forms, allowing for your testing and reporting processes to run smoothly. Please call **1-800-547-6165** with any questions.

Sincerely,

Helomics Corporation





HELOMICS®

WHO IS HELOMICS®?

Helomics Corporation is a comprehensive personalized healthcare company, bringing the next generation of diagnostics to the oncology field by putting **patients first, therapies second**. Our in-depth approach to **characterizing patients' live and archived cancer cells** allows us to create personal tumor profiles that help physicians to **individualize treatment options** for their patients. Helomics' tests provide vital information based on the specific biology and live response of each individual's cancer.

WHAT IS CHEMOFX®?

ChemoFx determines how an individual gynecologic cancer patient is likely to **respond to various types of chemotherapy** by testing the treatment options on that patient's **live** cancer cells and measuring cell response. ChemoFx provides valuable insights that help **guide physicians' treatment decisions**, giving you an edge against gynecologic cancer.

WHY CHEMOFX?

Your physician is using every advantage available to improve the odds in your fight against cancer. ChemoFx is designed to **reduce your risk of receiving therapies that are ineffective** or to **identify alternatives** when the typical treatments recommended for your type of cancer cannot be tolerated.

WHAT IS BIOSPECIFX®?

BioSpeciFx is a group of clinically relevant cancer-related **biomarker tests** that look to your genetics to predict your cancer's **response to various types of chemotherapy** and/or the course your disease is likely to take. The biomarkers included in BioSpeciFx testing are well validated and supported by current research and key opinion leaders.

WHY BIOSPECIFX?

Physicians utilize BioSpeciFx test results to help them better understand the **unique characteristics** of your particular cancer. The results can help them choose between multiple, equivalent therapies, to make decisions on how aggressively to treat your cancer, or to suggest certain **clinical trials** for you, if you should qualify.



Dear Patient:

Helomics Corporation offers financial assistance for its services to eligible individuals. Based on your financial need, either reduced payments or free care may be available.

Please sign and return this application to:

Helomics Corporation
91 43rd Street
Pittsburgh, PA 15201

OR

Fax to 1-800-549-6407

For any questions or concerns with completing this form, please call 888-522-7087.

Sincerely,

Helomics Corporation

91 43rd Street
Suite 110
Pittsburgh, PA 15201





COMPASSIONATE CARE APPLICATION

Patient Name: _____

Patient Date of Birth: _____

Patient Address: _____

Patient Email: _____

Total Annual Household Income: _____

Number of dependents including patient: _____

Any relevant circumstances we should know about (e.g. Job Loss, Retirement):

Application Declaration

I attest that the information provided is true and correct to the best of my knowledge. I agree that at any time during my enrollment, Helomics Corporation may request additional documents to authenticate the statements made on my application. I understand that Helomics Corporation reserves the right to change or discontinue this program at any time.

Patient/Guardian Signature: _____

Date: _____



PATIENT AUTHORIZATION AND CONSENT FORM

1. AUTHORIZATION FOR TESTING.

- a. I understand that I will be scheduled for removal of tissue/fluid. My physician may request that Helomics® Corporation perform laboratory tests on this tissue/fluid (sample). If these tests are ordered by my physician, I authorize Helomics to perform such tests. The results of these tests will be sent to my physician, which may be used in making clinical decisions regarding my care.
- b. I authorize my physician(s) to provide Helomics personal health information regarding my diagnosis and treatment.
- c. Helomics does not guarantee that the sample will be useful for any ordered tests, either on the date provided to Helomics or thereafter.
- d. After the sample has been used for diagnostic testing for which the sample was submitted to Helomics, or within six months of submission of the sample if no diagnostic testing was requested, I grant Helomics permission to store and/or use the excess sample taken from me for possible future use and testing for as long as Helomics, in its sole discretion deems appropriate. I authorize Helomics to dispose of my sample within strict adherence to regulatory guidelines.
- e. I donate any sample that would otherwise be discarded, to a research repository, and grant Helomics, and its assignees, permission to use the sample, and related medical and scientific information, for any purposes, including research and commercial development. Neither I nor my heirs shall receive compensation for my gift and will not retain ownership of it or developments therefrom. If I do not want to make such a gift, I will strike this paragraph and initial next to it. Striking this paragraph will not affect Helomics' processing of my sample for the tests requested by my physician.
- f. My personal information will not be sold by Helomics to any person, institution, or company for financial gain or commercial profit.
- g. To the extent any sample donated by me, or data derived therefrom, is used for research or commercial development purposes, it will be de-identified.

2. AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS. I authorize the release of any medical and insurance information necessary to support and process claims for services provided by Helomics. I assign my right to receive payment to Helomics and authorize any third party payer, including insurance company, to make payment to Helomics for all services provided by Helomics. If I receive payment from a third party payer for services provided by Helomics, I will remit such payment to Helomics.

3. APPOINTMENT OF REPRESENTATIVE. I appoint Helomics to act on my behalf as a representative in connection with any claim for coverage or benefits, including receipts of any approvals or authorization that are required before medical services are rendered. I authorize my representative to receive any and all information with respect to the services provided by Helomics and to act on my behalf, to provide any information to a third party payer that relates to any claim for coverage or benefits.

4. ASSIGNMENT OF APPEAL RIGHTS. I appoint and authorize Helomics to pursue all necessary appeals of full or partial denials of coverage and/or payment on my behalf with respect to any third party payer for services provided by Helomics.

I have carefully read the foregoing, discussed any questions I had with my physician, and hereby execute this authorization for laboratory testing, authorization for the release of medical and insurance information, assignment of payment, appointment of representative and assignment of appeal rights.

Patient Name *(Please Print)*

_____/_____/_____
Patient Date of Birth

Patient / Healthcare Power of Attorney *(Signature)*

_____/_____/_____
Signature Date

Person Obtaining Consent *(Signature)*

Name of Patient's Physician *(Please Print)*

_____/_____/_____
Date of Surgery



As a cancer patient and recipient of treatments developed with the assistance of those who contributed before you, this is an opportunity to help others who could benefit from your generosity.

With your consent, the data generated from your tissue can help develop the next generation of therapies to help many more cancer patients.

Any patient specific demographic information will be anonymous and never released to a third party and you will not incur any additional expense with your donation.

Ordering Physician: _____

Patient Name: _____

Patient DOB: _____

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for items or services below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the items or services below.

Items or Services	Reason Medicare May Not Pay:	Estimated Cost
ChemoFx	Non-covered service	\$450-\$615

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the items or services listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

OPTIONS: Check only one box. We cannot choose a box for you.

OPTION 1. I want the items or services listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

OPTION 2. I want the items or services listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

OPTION 3. I don't want the items or services listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	Date:
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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.