CellsBin, Inc.
25 Business Park Drive, Branford, CT 06405
CLIA ID: 07D2336599 | CT License: CLAB.1158

TEST REQUISITION FORM
CB-Scout™ BCMA CAR-T
Form CSB-REQ-001 · v2.1 DRAFT · 10/2026

1. TEST ORDERED

☐ **CB-Scout™ BCMA CAR-T** — quantitative enumeration of circulating BCMA CAR-T cells (Laboratory Developed Test)

Order type (check one): ☐ **Initial order** — first post-infusion test; reference specimens 2A and 2B submitted with this order
☐ **Follow-up time point** — reference specimens already on file CellsBin Patient ID (follow-up): _____

How many tests? Each post-infusion specimen (2C) is one test, reported separately. The pre-infusion PBMC (2A) and infusion-product aliquot (2B) are **submitted once per patient** as analytical references. They are required to build the patient-specific model and are not reported or billed as separate tests. Additional post-infusion time points are ordered at the treating physician's discretion with a new requisition.

2. SPECIMEN INFORMATION

#	SPECIMEN	SUBMIT	COLLECTION DATE	TIME	DAYS POST-INFUSION	# VIALS	CELLS/VIAL (×10⁶)
2A	Pre-infusion PBMC (negative reference), cryopreserved	Initial order only			N/A		
2B	CAR-T infusion product aliquot (positive reference), cryopreserved	Initial order only			Day 0		
2C	Post-infusion PBMC (tested specimen), cryopreserved	Every order					

Specimen requirements: Cryopreserved peripheral blood mononuclear cells (PBMCs) only. Whole blood, bone marrow, and other specimen types are not accepted. Keep frozen (≤ −80 °C or liquid nitrogen) and **ship frozen on dry ice by overnight courier** with this completed form. Label each vial with two patient identifiers, specimen designation (2A/2B/2C), and collection date. Specimens received thawed are rejected.

3. ORDERING PROVIDER

ORDERING PHYSICIAN (LAST, FIRST) | NPI | PHONE

ORGANIZATION / FACILITY | FAX | EMAIL FOR RESULTS

STREET ADDRESS | CITY, STATE, ZIP

NON-PHYSICIAN PROVIDER (IF APPLICABLE) | PROVIDER NPI / ID | ADDITIONAL REPORT RECIPIENT

4. PATIENT INFORMATION

LAST NAME | FIRST NAME | DATE OF BIRTH (MM/DD/YYYY) | SEX AT BIRTH ☐ Male ☐ Female

MRN / PATIENT ID | STREET ADDRESS | CITY, STATE, ZIP

PHONE | MOBILE | EMAIL (OPTIONAL)

5. CLINICAL INFORMATION

DIAGNOSIS / ICD-10 (CHECK ALL THAT APPLY)
☐ C90.00 ☐ C90.01 ☐ C90.02 Other: _____

BCMA-DIRECTED CAR-T PRODUCT
☐ Ciltacabtagene autoleucel ☐ Idecabtagene vicleucel Other: _____

CAR-T INFUSION DATE (MM/DD/YYYY) | RELEVANT CLINICAL HISTORY / PRIOR THERAPY

6. BILLING INFORMATION

Bill to: ☐ Client / facility ☐ Medicare ☐ Medicaid ☐ Commercial insurance ☐ Patient / self-pay

PRIMARY INSURANCE COMPANY	MEMBER / INSURED ID #	GROUP #

INSURANCE ADDRESS	PATIENT RELATIONSHIP TO INSURED ☐ Self ☐ Spouse ☐ Dependent ☐ Other

INSURED NAME (IF NOT PATIENT)	INSURED DATE OF BIRTH	SECONDARY INSURANCE / ID (IF ANY)

Please attach a copy of the front and back of the patient's insurance card(s). For client/facility billing, the ordering facility is invoiced per its CellsBin agreement.

7. PHYSICIAN ATTESTATION

I certify that the test ordered above is medically necessary for the management of this patient, that the information provided is accurate, and that the patient has been informed of the testing. This test is a Laboratory Developed Test validated and performed by CellsBin, Inc. under CLIA. It has not been cleared or approved by the U.S. FDA.

ORDERING PROVIDER SIGNATURE (AUTHORIZED ELECTRONIC SIGNATURES ACCEPTED)	DATE

8. PATIENT AUTHORIZATION, FINANCIAL RESPONSIBILITY & CONSENT

By signing below, I authorize CellsBin, Inc. to perform the requested laboratory testing on my specimens, to release results to my ordering provider and to my insurance carrier for treatment and reimbursement, and to receive insurance benefits payable for this testing directly. I understand that I may be financially responsible for any balance not covered by my insurance, as permitted by law.

PATIENT / AUTHORIZED REPRESENTATIVE SIGNATURE	DATE

PRINTED NAME	RELATIONSHIP TO PATIENT (IF NOT PATIENT)

9. HOW TO ORDER & SUBMIT

1. Select **Order** on cellsbin.com/for-physicians, or download this form there.
2. Complete sections 1–8 and email the form to **scout@cellsbin.com**. CellsBin confirms receipt and provides shipping instructions and a dry-ice shipping kit.
3. Ship specimens frozen on dry ice by overnight courier with a printed copy of this form to: CellsBin, Inc., Attn: Clinical Laboratory, 25 Business Park Drive, Branford, CT 06405.
4. Results are reported to the ordering provider by secure fax/email or the CellsBin portal. For questions, contact scout@cellsbin.com.

For laboratory use only — Accession #: _____ Received (date/time): _____ Condition on receipt: ☐ Frozen ☐ Thawed (reject)
Received by: _____