

ABOUT THE TEST FoundationOne®Liquid CDx is a next generation sequencing (NGS) assay that identifies clinically relevant genomic alterations in circulating cell-free DNA.

PATIENT	DISEASE Pancreas ductal adenocarcinoma	PHYSICIAN	ORDERING PHYSICIAN Yeh, Yi-Chen	SPECIMEN	SPECIMEN ID HCC 8/31/1954
	NAME Chien, Hsiu-Ching		MEDICAL FACILITY Taipei Veterans General Hospital		SPECIMEN TYPE Blood
	DATE OF BIRTH 31 August 1954		ADDITIONAL RECIPIENT None		DATE OF COLLECTION 08 June 2023
	SEX Female		MEDICAL FACILITY ID 205872		SPECIMEN RECEIVED 13 June 2023
	MEDICAL RECORD # 49502321		PATHOLOGIST Not Provided		

Biomarker Findings

Blood Tumor Mutational Burden - 1 Muts/Mb
Microsatellite status - MSI-High Not Detected
Tumor Fraction - Elevated Tumor Fraction Not Detected

Genomic Findings

For a complete list of the genes assayed, please refer to the Appendix.

No reportable genomic alterations were detected. See below for more information.

Report Highlights

- There are no highlights associated with this patient's genomic findings.

For more information on potential biological and clinical significance, see the Biomarker and Genomic Findings sections.

REPORT UPDATES

Amended Report 11-Jul-2023

This Amended Report has been issued to reflect a change in Tumor Type from "Unknown primary adenocarcinoma" to "Pancreas ductal adenocarcinoma." Please note that other aspects of this report may have changed from the previous version to reflect the most up-to-date reporting information. Please reach out to your local customer care support line at (<https://www.rochefoundationmedicine.com/home/contact-us.html> [[rochefoundationmedicine.com](https://www.rochefoundationmedicine.com)]) with any questions or concerns.

Original Report Date: 20-Jun-2023

BIOMARKER FINDINGS

Blood Tumor Mutational Burden -
 1 Muts/Mb

Microsatellite status -
 MSI-High Not Detected

Tumor Fraction -
 Elevated Tumor Fraction Not Detected

THERAPY AND CLINICAL TRIAL IMPLICATIONS

No therapies or clinical trials. See Biomarker Findings section

MSI-High not detected. No evidence of microsatellite instability in this sample (see Appendix section).

Tumor fraction is considered elevated when ctDNA levels are high enough that aneuploidy can be detected. The fact that elevated tumor fraction was not detected in this specimen indicates the possibility of lower levels of ctDNA but does not compromise confidence in any reported alterations. However, in the setting of a negative liquid biopsy result, orthogonal testing of a tissue specimen should be considered if clinically indicated (see Biomarker Findings section).

No therapies or clinical trials are associated with the Genomic Findings for this sample.

If you have questions or comments about this result, please contact your local Customer Service team
(<https://www.rochefoundationmedicine.com/home/contact-us.html>)

NOTE Genomic alterations detected may be associated with activity of certain approved therapies; however, the therapies listed in this report may have varied clinical evidence in the patient's tumor type. Therapies and the clinical trials listed in this report may not be complete and/or exhaustive. Neither the therapies nor the trials identified are ranked in order of potential or predicted efficacy for this patient, nor are they ranked in order of level of evidence for this patient's tumor type. This report should be regarded and used as a supplementary source of information and not as the single basis for the making of a therapy decision. All treatment decisions remain the full and final responsibility of the treating physician and physicians should refer to approved prescribing information for all therapies. Therapies contained in this report may have been approved by the US FDA or other national authorities; however, they might not have been approved in your respective country. In the appropriate clinical context, germline testing of *APC*, *ATM*, *BAP1*, *BRCA1*, *BRCA2*, *BRIP1*, *CHEK2*, *FH*, *FLCN*, *MEN1*, *MLH1*, *MSH2*, *MSH6*, *MUTYH*, *NF1*, *NF2*, *PALB2*, *PMS2*, *POLE*, *PTEN*, *RAD51C*, *RAD51D*, *RB1*, *RET*, *SDHA*, *SDHB*, *SDHC*, *SDHD*, *SMAD4*, *STK11*, *TGFBR2*, *TP53*, *TSC1*, *TSC2*, *VHL*, and *WT1* is recommended.

Variant Allele Frequency is not applicable for copy number alterations.

ORDERED TEST # **ORD-1650540-01**

HISTORIC PATIENT FINDINGS	ORD-1650540-01 VAF%
Blood Tumor Mutational Burden	1 Muts/Mb
Microsatellite status	MSI-High Not Detected
Tumor Fraction	Elevated Tumor Fraction Not Detected

IMPORTANT NOTE This comparison table refers only to genes and biomarkers assayed by prior FoundationOne®Liquid CDx or FoundationOne®CDx tests. Up to five previous tests may be shown.

For some genes in FoundationOne Liquid CDx, only select exons are assayed. Therefore, an alteration found by a previous test may not have been confirmed despite overlapping gene lists. Please refer to the Appendix for the complete list of genes and exons assayed. Variants reported for prior time points reflect reporting practices at the time of the historical test(s). Changes in variant reporting nomenclature, classification, or handling may result in the appearance of discrepancies across time points. The gene and biomarker list will be updated periodically to reflect new knowledge about cancer biology.

As new scientific information becomes available, alterations that had previously been listed as Variants of Unknown Significance (VUS) may become reportable or reportable variants may become VUS.

Tissue Tumor Mutational Burden (TMB) and blood TMB (bTMB) are estimated from the number of synonymous and non-synonymous single-nucleotide variants (SNVs) and insertions and deletions (indels) per area of coding genome sampled, after the removal of known and likely oncogenic driver events and germline SNPs. Tissue TMB is calculated based on variants with an allele frequency of $\geq 5\%$, and bTMB is calculated based on variants with an allele frequency of $\geq 0.5\%$.

Not Tested = not baited, not reported on test, or test preceded addition of biomarker or gene

Not Detected = baited but not detected on test

Detected = present (VAF% is not applicable)

VAF% = variant allele frequency percentage

Cannot Be Determined = Sample is not of sufficient data quality to confidently determine biomarker status

Please note that other aspects of this table may have changed from the previous version to reflect the most up-to-date reporting information.

ORDERED TEST # ORD-1650540-01

BIOMARKER FINDINGS

BIOMARKER

Blood Tumor Mutational Burden

RESULT

1 Muts/Mb

POTENTIAL TREATMENT STRATEGIES

— Targeted Therapies —

On the basis of clinical evidence in solid tumors, increased blood tumor mutational burden (bTMB) may be associated with greater sensitivity to immunotherapeutic agents, including anti-PD-L1¹⁻³, anti-PD-1³⁻⁴, anti-PD-1/CTLA4 therapies⁵⁻⁶, anti-PD-L1/CTLA4 therapies⁷⁻¹⁰. A Phase 2 multi-solid-tumor trial showed that bTMB ≥ 16 Muts/Mb (as measured by this assay) was associated with improved survival from treatment with a PD-1 inhibitor alone or in combination with a CTLA-4 inhibitor⁵. In non-small cell lung cancer (NSCLC), multiple clinical trials have shown patients with higher bTMB derive clinical benefit from immune checkpoint inhibitors following single-agent or combination treatments with either CTLA4

inhibitors or chemotherapy, with reported high bTMB cutpoints ranging from 6 Muts/Mb-16 Muts/Mb^{1,8-10}. In head and neck squamous cell carcinoma (HNSCC), a Phase 3 trial showed that bTMB ≥ 16 Muts/Mb (approximate equivalency ≥ 8 Muts/Mb as measured by this assay) was associated with improved survival from treatment with a PD-L1 inhibitor alone or in combination with a CTLA-4 inhibitor¹¹. In colorectal cancer (CRC), a Phase 2 study showed that bTMB ≥ 28 Muts/Mb (approximate equivalency ≥ 14 Muts/Mb as measured by this assay) was associated with improved OS from a PD-L1 inhibitor alone or in combination with a CTLA-4 inhibitor⁷.

FREQUENCY & PROGNOSIS

Average bTMB levels in solid tumors other than NSCLC have not been evaluated (PubMed, Mar 2023). Published data investigating the prognostic implications of bTMB levels in pancreatic carcinoma are limited (PubMed, Jul 2023). A study of patients with pancreatic ductal adenocarcinoma harboring mismatch repair gene mutations reported improved prognosis for patients with high TMB measured in tissue samples (defined as >50 mutations; survival 69-314 months) compared

to those with lower TMB (average of 5.7 mutations; 10-42 months)¹².

FINDING SUMMARY

Blood tumor mutational burden (bTMB, also known as mutation load) is a measure of the number of somatic protein-coding base substitution and insertion/deletion mutations from circulating tumor DNA in blood. TMB is affected by a variety of causes, including exposure to mutagens such as ultraviolet light in melanoma¹³⁻¹⁴ and cigarette smoke in lung cancer¹⁵⁻¹⁶, treatment with temozolomide-based chemotherapy in glioma¹⁷⁻¹⁸, mutations in the proofreading domains of DNA polymerases encoded by the POLE and POLD1 genes¹⁹⁻²³, and microsatellite instability (MSI)^{19,22-23}. High bTMB levels were not detected in this sample. It is unclear whether the bTMB levels in this sample would be predicted to be associated with sensitivity to PD-1- or PD-L1-targeting immune checkpoint inhibitors, alone or in combination with other agents^{1-2,4}. Depending on the clinical context, TMB testing of an alternate sample or by another methodology could be considered.

BIOMARKER

Tumor Fraction

RESULT

Elevated Tumor Fraction Not Detected

POTENTIAL TREATMENT STRATEGIES

— Targeted Therapies —

Specimens with elevated tumor fraction values have high circulating-tumor DNA (ctDNA) content, and thus higher sensitivity for identifying genomic alterations. Such specimens are at a lower risk of false negative results. However, if elevated tumor fraction is not detected, it does not exclude the presence of disease burden or compromise the confidence of reported alterations. Tumor fraction levels currently have limited implications for diagnosis, surveillance, or therapy and should not

be overinterpreted or compared from one blood draw to another. There are currently no targeted approaches to address specific tumor fraction levels. In the research setting, changes in tumor fraction estimates have been associated with treatment duration and clinical response and may be a useful indicator for future cancer management²⁴⁻²⁹.

FREQUENCY & PROGNOSIS

Detectable ctDNA levels have been reported in a variety of tumor types, with higher tumor fraction levels reported for patients with metastatic (Stage 4) tumors compared with patients with localized disease (Stages 1 to 3)³⁰. Elevated tumor fraction levels have been reported to be associated with worse prognosis in a variety of cancer types, including pancreatic cancer³¹, Ewing sarcoma and osteosarcoma³², prostate cancer²⁷, breast cancer³³, leiomyosarcoma³⁴, esophageal cancer³⁵, colorectal

cancer³⁶, and gastrointestinal cancer³⁷.

FINDING SUMMARY

Tumor fraction provides an estimate of the percentage of ctDNA present in a cell-free DNA (cfDNA) sample. The tumor fraction estimate for this sample is based on the observed level of aneuploid instability. The tumor fraction algorithm utilized for FoundationOne Liquid CDx uses the allele frequencies of approximately 1,000 single-nucleotide polymorphism (SNP) sites across the genome. Unlike the maximum somatic allele frequency (MSAF) method of estimating ctDNA content³⁸, the tumor fraction metric does not take into account the allele frequency of individual variants but rather produces a more holistic estimate of ctDNA content using data from across the genome. The amount of ctDNA detected may correlate with disease burden and response to therapy³⁹⁻⁴⁰.

ORDERED TEST # ORD-1650540-01

APPENDIX
Variants of Unknown Significance

NOTE One or more variants of unknown significance (VUS) were detected in this patient's tumor. These variants may not have been adequately characterized in the scientific literature at the time this report was issued, and/or the genomic context of these alterations makes their significance unclear. We choose to include them here in the event that they become clinically meaningful in the future.

ALOX12B

 NM_001139.2: c.1921G>A
(p.D641N)
chr17:7976471

MERTK

 NM_006343.2: c.1874A>G
(p.N625S)
chr2:112765966

MSH2

 NM_000251.1: c.505A>G
(p.I169V)
chr2:47637371

NOTCH3

 NM_000435.2: c.499C>T
(p.P167S)
chr19:15302951

PARP1

 NM_001618.3: c.14C>G
(p.S5W)
chr1:226595617

PTCH1

 NM_001083603.1: c.131A>G
(p.E44G)
chr9:98278972 and
NM_000264.3: c.2479A>G
(p.S827G)
chr9:98229479

ROS1

 NM_002944.2: c.4813G>C
(p.E1605Q)
chr6:117662652

SDHA

 NM_004168.2: c.739A>G
(p.I247V)
chr5:228417

ORDERED TEST # ORD-1650540-01

APPENDIX

Genes assayed in FoundationOne®Liquid CDx

FoundationOne Liquid CDx interrogates 324 genes, including 309 genes with complete exonic (coding) coverage and 15 genes with only select non-coding coverage (indicated with an *); 75 genes (indicated in bold) are captured with increased sensitivity and have complete exonic (coding) coverage unless otherwise noted.

ABL1 Exons 4-9	ACVR1B	AKT1 Exon 3	AKT2	AKT3	ALK Exons 20-29, Introns 18, 19	ALOX12B	AMER1 (FAM123B or WTX)	APC
AR	ARAF Exons 4, 5, 7, 11, 13, 15, 16	ARFRP1	ARID1A	ASXL1	ATM	ATR	ATRX	AURKA
AURKB	AXIN1	AXL	BAP1	BARD1	BCL2	BCL2L1	BCL2L2	BCL6
BCOR	BCORL1	BCR* Introns 8, 13, 14	BRAF Exons 11-18, Introns 7-10	BRCA1 Introns 2, 7, 8, 12, 16, 19, 20	BRCA2 Intron 2	BRD4	BRIP1	BTG1
BTG2	BTK Exons 2, 15	CALR	CARD11	CASP8	CBFB	CBL	CCND1	CCND2
CCND3	CCNE1	CD22	CD70	CD74* Introns 6-8	CD79A	CD79B	CD274 (PD-L1)	CDC73
CDH1	CDK12	CDK4	CDK6	CDK8	CDKN1A	CDKN1B	CDKN2A	CDKN2B
CDKN2C	CEBPA	CHEK1	CHEK2	CIC	CREBBP	CRKL	CSF1R	CSF3R
CTCF	CTNNA1	CTNNB1 Exon 3	CUL3	CUL4A	CXCR4	CYP17A1	DAXX	DDR1
DDR2 Exons 5, 17, 18	DIS3	DNMT3A	DOT1L	EED	EGFR Introns 7, 15, 24-27	EMSY (C11orf30)	EP300	EPHA3
EPHB1	EPHB4	ERBB2	ERBB3 Exons 3, 6, 7, 8, 10, 12, 20, 21, 23, 24, 25	ERBB4	ERCC4	ERG	ERRFI1	ESR1 Exons 4-8
ETV4* Intron 8	ETV5* Introns 6, 7	ETV6* Introns 5, 6	EWSR1* Introns 7-13	EZH2 Exons 4, 16, 17, 18	EZR* Introns 9-11	FANCA	FANCC	FANCG
FANCL	FAS	FBXW7	FGF10	FGF12	FGF14	FGF19	FGF23	FGF3
FGF4	FGF6	FGFR1 Introns 1, 5, Intron 17	FGFR2 Intron 1, Intron 17	FGFR3 Exons 7, 9 (alternative designation exon 10), 14, 18, Intron 17	FGFR4	FH	FLCN	FLT1
FLT3 Exons 14, 15, 20	FOXL2	FUBP1	GABRA6	GATA3	GATA4	GATA6	GID4 (C17orf39)	GNAI1 Exons 4, 5
GNA13	GNAQ Exons 4, 5	GNAS Exons 1, 8	GRM3	GSK3B	H3-3A (H3F3A)	HDAC1	HGF	HNF1A
HRAS Exons 2, 3	HSD3B1	ID3	IDH1 Exon 4	IDH2 Exon 4	IGF1R	IKBKE	IKZF1	INPP4B
IRF2	IRF4	IRS2	JAK1	JAK2 Exon 14	JAK3 Exons 5, 11, 12, 13, 15, 16	JUN	KDM5A	KDM5C
KDM6A	KDR	KEAP1	KEL	KIT Exons 8, 9, 11, 12, 13, 17, Intron 16	KLHL6	KMT2A (MLL) Introns 6, 8-11, Intron 7	KMT2D (MLL2)	KRAS

© 2023 Foundation Medicine, Inc. All rights reserved.

Electronically signed by Mirna Lechpammer, M.D., Ph.D. | 11 July 2023
Julia Elvin, M.D., Ph.D., Laboratory Director CLIA: 22D2027531
Nimesh R. Patel, M.D., Laboratory Director CLIA: 34D2044309
Foundation Medicine, Inc. | www.rochefoundationmedicine.com

Sample Preparation: 150 Second St., 1st Floor, Cambridge, MA 02141 • CLIA: 22D2027531
Sample Analysis: 150 Second St., 1st Floor, Cambridge, MA 02141 • CLIA: 22D2027531
Post-Sequencing Analysis: 150 Second St., 1st Floor, Cambridge, MA 02141 • CLIA: 22D2027531

ORDERED TEST # ORD-1650540-01

APPENDIX
Genes assayed in FoundationOne® Liquid CDx

FoundationOne Liquid CDx interrogates 324 genes, including 309 genes with complete exonic (coding) coverage and 15 genes with only select non-coding coverage (indicated with an *); 75 genes (indicated in bold) are captured with increased sensitivity and have complete exonic (coding) coverage unless otherwise noted.

<i>LTK</i>	<i>LYN</i>	<i>MAF</i>	MAP2K1 (MEK1) Exons 2, 3	MAP2K2 (MEK2) Exons 2-4, 6, 7	<i>MAP2K4</i>	<i>MAP3K1</i>	<i>MAP3K13</i>	<i>MAPK1</i>
<i>MCL1</i>	MDM2	<i>MDM4</i>	<i>MED12</i>	<i>MEF2B</i>	<i>MEN1</i>	<i>MERTK</i>	MET	<i>MITF</i>
<i>MKNK1</i>	<i>MLH1</i>	MPL Exon 10	<i>MRE11</i> (MRE11A)	<i>MSH2</i> Intron 5	<i>MSH3</i>	<i>MSH6</i>	<i>MST1R</i>	<i>MTAP</i>
MTOR Exons 19, 30, 39, 40, 43-45, 47, 48, 53, 56	<i>MUTYH</i>	<i>MYB*</i> Intron 14	MYC Intron 1	<i>MYCL</i> (MYCL1)	MYCN	MYD88 Exon 4	<i>NBN</i>	NF1
<i>NF2</i>	<i>NFE2L2</i>	<i>NFKBIA</i>	<i>NKX2-1</i>	<i>NOTCH1</i>	<i>NOTCH2</i> Intron 26	<i>NOTCH3</i>	NPM1 Exons 4-6, 8, 10	NRAS Exons 2, 3
<i>NSD2</i> (WHSC1 or MMSET)	<i>NSD3</i> (WHSC1L1)	<i>NT5C2</i>	NTRK1 Exons 14, 15, Introns 8-11	<i>NTRK2</i> Intron 12	NTRK3 Exons 16, 17	<i>NUTM1*</i> Intron 1	<i>P2RY8</i>	PALB2
<i>PARP1</i>	<i>PARP2</i>	<i>PARP3</i>	<i>PAX5</i>	<i>PBRM1</i>	<i>PDCD1</i> (PD-1)	PDCD1LG2 (PD-L2)	PDGFRA Exons 12, 18, Introns 7, 9, 11	PDGFRB Exons 12-21, 23
<i>PDK1</i>	<i>PIK3C2B</i>	<i>PIK3C2G</i>	PIK3CA Exons 2, 3, 5-8, 10, 14, 19, 21 (Coding Exons 1, 2, 4-7, 9, 13, 18, 20)	<i>PIK3CB</i>	<i>PIK3R1</i>	<i>PIM1</i>	<i>PMS2</i>	<i>POLD1</i>
<i>POLE</i>	<i>PPARG</i>	<i>PPP2R1A</i>	<i>PPP2R2A</i>	<i>PRDM1</i>	<i>PRKAR1A</i>	<i>PRKCI</i>	<i>PRKN</i> (PARK2)	<i>PTCH1</i>
PTEN	PTPN11	<i>PTPRO</i>	<i>QKI</i>	<i>RAC1</i>	<i>RAD21</i>	<i>RAD51</i>	<i>RAD51B</i>	<i>RAD51C</i>
<i>RAD51D</i>	<i>RAD52</i>	<i>RAD54L</i>	RAF1 Exons 3, 4, 6, 7, 10, 14, 15, 17, Introns 4-8	<i>RARA</i> Intron 2	RB1	<i>RBM10</i>	<i>REL</i>	RET Introns 7, 8, Exons 11, 13-16, Introns 9-11
<i>RICTOR</i>	<i>RNF43</i>	ROS1 Exons 31, 36-38, 40, Introns 31-35	<i>RPTOR</i>	<i>RSP02*</i> Intron 1	<i>SDC4*</i> Intron 2	<i>SDHA</i>	<i>SDHB</i>	<i>SDHC</i>
<i>SDHD</i>	<i>SETD2</i>	<i>SF3B1</i>	<i>SGK1</i>	<i>SLC34A2*</i> Intron 4	<i>SMAD2</i>	<i>SMAD4</i>	<i>SMARCA4</i>	<i>SMARCB1</i>
SMO	<i>SNCAIP</i>	<i>SOC1</i>	<i>SOX2</i>	<i>SOX9</i>	<i>SPEN</i>	<i>SPOP</i>	<i>SRC</i>	<i>STAG2</i>
<i>STAT3</i>	STK11	<i>SUFU</i>	<i>SYK</i>	<i>TBX3</i>	<i>TEK</i>	<i>TENT5C</i> (FAM46C)	<i>TERC*</i> ncRNA	TERT* Promoter
<i>TET2</i>	<i>TGFBR2</i>	<i>TIPARP</i>	<i>TMPRSS2*</i> Introns 1-3	<i>TNFAIP3</i>	<i>TNFRSF14</i>	TP53	<i>TSC1</i>	<i>TSC2</i>
<i>TYRO3</i>	<i>U2AF1</i>	VEGFA	<i>VHL</i>	<i>WT1</i>	<i>XPO1</i>	<i>XRCC2</i>	<i>ZNF217</i>	<i>ZNF703</i>

ADDITIONAL ASSAYS: FOR THE DETECTION OF SELECT CANCER BIOMARKERS

Microsatellite (MS) status
Blood Tumor Mutational Burden (bTMB)
Tumor Fraction

ORDERED TEST # ORD-1650540-01

APPENDIX

About FoundationOne® Liquid CDx

FoundationOne Liquid CDx fulfills the requirements of the European Directive 98/79 EC for in vitro diagnostic medical devices and is registered as a CE-IVD product by Foundation Medicine's EU Authorized Representative, Qarad b.v.b.a, Ciplastraat 3, 2440 Geel, Belgium. The CE-IVD regulatory status of FoundationOne Liquid CDx is applicable in countries that accept and/or recognize the CE mark.



ABOUT FOUNDATIONONE LIQUID CDx

FoundationOne Liquid CDx was developed and its performance characteristics determined by Foundation Medicine, Inc. (Foundation Medicine). FoundationOne Liquid CDx may be used for clinical purposes and should not be regarded as purely investigational or for research only. Foundation Medicine's clinical reference laboratories are qualified to perform high-complexity clinical testing.

Please refer to technical information for performance specification details.

INTENDED USE

FoundationOne Liquid CDx is a next generation sequencing based *in vitro* diagnostic device that analyzes 324 genes. Substitutions and insertion and deletion alterations (indels) are reported in 311 genes, copy number alterations (CNAs) are reported in 310 genes, and gene rearrangements are reported in 324 genes. The test also detects the genomic signatures blood tumor mutational burden (bTMB), microsatellite instability (MSI), and tumor fraction. FoundationOne Liquid CDx utilizes circulating cell-free DNA (cfDNA) isolated from plasma derived from the anti-coagulated peripheral whole blood of cancer patients. The test is intended to be used as a companion diagnostic to identify patients who may benefit from treatment with targeted therapies in accordance with the approved therapeutic product labeling. Additionally, FoundationOne Liquid CDx is intended to provide tumor mutation profiling to be used by qualified health care professionals in accordance with professional guidelines in oncology for patients with malignant neoplasms.

TEST PRINCIPLES

The FoundationOne Liquid CDx assay is performed exclusively as a laboratory service using circulating cell-free DNA (cfDNA) isolated from plasma derived from anti-coagulated peripheral whole blood from patients with solid malignant neoplasms. The assay employs a single DNA extraction method to obtain cfDNA from plasma from whole blood. Extracted

cfDNA undergoes whole-genome shotgun library construction and hybridization-based capture of 324 cancer-related genes including coding exons and select introns of 309 genes, as well as only select intronic regions or non-coding regions of 15 genes. Hybrid-capture selected libraries are sequenced with deep coverage using the NovaSeq® 6000 platform. Sequence data are processed using a customized analysis pipeline designed to accurately detect genomic alterations, including base substitutions, indels, select copy number variants, and select genomic rearrangements. Substitutions and insertion and deletion alterations (indels) are reported in 311 genes, copy number alterations (CNAs) are reported in 310 genes, and gene rearrangements are reported in 324 genes. The assay also reports tumor fraction, and genomic signatures including MSI and bTMB. A subset of targeted regions in 75 genes is baited for increased sensitivity.

THE REPORT

Incorporates analyses of peer-reviewed studies and other publicly available information identified by Foundation Medicine; these analyses and information may include associations between a molecular alteration (or lack of alteration) and one or more drugs with potential clinical benefit (or potential lack of clinical benefit), including drug candidates that are being studied in clinical research. *Note:* A finding of biomarker alteration does not necessarily indicate pharmacologic effectiveness (or lack thereof) of any drug or treatment regimen; a finding of no biomarker alteration does not necessarily indicate lack of pharmacologic effectiveness (or effectiveness) of any drug or treatment regimen.

QUALIFIED ALTERATION CALLS (EQUIVOCAL)

All equivocal calls, regardless of alteration type, imply that there is adequate evidence to call the alteration with confidence. However, the repeatability of equivocal calls may be lower than non-equivocal calls.

RANKING OF THERAPIES AND CLINICAL TRIALS

Ranking of Therapies in Summary Table
Therapies are ranked based on the following criteria: Therapies with clinical benefit (ranked alphabetically within each evidence category), followed by therapies associated with resistance (when applicable).

Ranking of Clinical Trials
Pediatric trial qualification → Geographical proximity → Later trial phase.

LIMITATIONS

1. For *in vitro* diagnostic use.
2. For prescription use only. This test must be ordered by a qualified medical professional in accordance with clinical laboratory regulations.
3. A negative result does not rule out the presence of a mutation below the limits of detection of the assay. Patients for whom no companion diagnostic alterations are detected should be considered for confirmation with an appropriately validated tumor tissue test, if available.
4. The FoundationOne Liquid CDx assay does not detect heterozygous deletions.
5. The test is not intended to provide information on cancer predisposition.
6. Performance has not been validated for cfDNA input below the specified minimum input.
7. Tissue TMB and blood TMB (bTMB) are estimated from the number of synonymous and nonsynonymous single-nucleotide variants (SNVs) and insertions and deletions (indels) per area of coding genome sampled, after the removal of known and likely oncogenic driver events and germline SNPs. Tissue TMB is calculated based on variants with an allele frequency of $\geq 5\%$, and bTMB is calculated based on variants with an allele frequency of $\geq 0.5\%$.
8. Tumor fraction is the percentage of circulating tumor DNA (ctDNA) present in a cell-free DNA (cfDNA) sample. The tumor fraction estimate is computationally derived from the observed level of aneuploidy in the sample. Tumor fraction is considered elevated when ctDNA levels are high enough that aneuploidy can be detected and is significantly distinct from that typically found in non-tumor samples.
9. Microsatellite instability (MSI) is a condition of genetic hypermutability that generates excessive amounts of short insertion/deletion mutations in the tumor genome; it generally occurs at microsatellite DNA sequences and is caused by a deficiency in DNA mismatch repair (MMR) in the tumor. The MSI algorithm is based on genome wide analysis of 1765 microsatellite loci and not based on the 5 or 7 MSI loci described in current clinical practice guidelines for solid tissue testing.
10. Genomic findings from circulating cell-free DNA (cfDNA) may originate from circulating tumor DNA fragments, germline alterations, or non-tumor somatic alterations, such as clonal hematopoiesis of indeterminate potential (CHIP). Genes with alterations that may be derived from CHIP include, but are not limited to: *ASXL1*, *ATM*, *CBL*, *CHEK2*, *DNMT3A*, *JAK2*,

ORDERED TEST # ORD-1650540-01

APPENDIX

About FoundationOne® Liquid CDx

KMT2D (MLL2), MPL, MYD88, SF3B1, TET2, TP53, and U2AF1.

11. Alterations reported may include somatic (not inherited) or germline (inherited) alterations; however, the test does not distinguish between germline and somatic alterations. If a reported alteration is suspected to be germline, confirmatory testing should be considered in the appropriate clinical context.
12. The test is not intended to replace germline testing or to provide information about cancer predisposition.

REPORT HIGHLIGHTS

The Report Highlights includes select genomic and therapeutic information with potential impact on patient care and treatment that is specific to the genomics and tumor type of the sample analyzed. This section may highlight information including targeted therapies with potential sensitivity or resistance; evidence-matched clinical trials; and variants with potential diagnostic, prognostic, nontargeted treatment, germline, or clonal hematopoiesis implications. Information included in the Report Highlights is expected to evolve with advances in scientific and clinical research. Findings included in the Report Highlights should be considered in the context of all other information in this report and other relevant patient information. Decisions on patient care and treatment are the responsibility of the treating physician.

VARIANTS TO CONSIDER FOR FOLLOW-UP GERMLINE TESTING

The variants indicated for consideration of follow-up germline testing are 1) limited to reportable short variants with a protein effect listed in the ClinVar genomic database (Landrum et al., 2018; 29165669) as Pathogenic, Pathogenic/Likely Pathogenic, or Likely Pathogenic (by an expert panel or multiple submitters), 2) associated with hereditary cancer-predisposing disorder(s), 3) detected at an allele frequency of >30%, and 4) in select genes reported by the ESMO Precision Medicine Working Group (Mandelker et al., 2019; 31050713) to have a greater than 10% probability of germline origin if identified during tumor sequencing. The selected genes are *ATM, BAP1, BRCA1, BRCA2, BRIP1, CHEK2, FH, FLCN, MLH1, MSH2, MSH6, MUTYH, PALB2, PMS2, POLE, RAD51C, RAD51D, RET, SDHA, SDHB, SDHC, SDHD, TSC2, and VHL*, and are not inclusive of all cancer susceptibility genes. The content in this report should not substitute for genetic counseling or follow-up germline testing, which is needed to distinguish whether a finding in this patient's

tumor sequencing is germline or somatic. Interpretation should be based on clinical context.

VARIANTS THAT MAY REPRESENT CLONAL HEMATOPOIESIS

Variants that may represent clonal hematopoiesis (CH) are limited to select reportable short variants in defined genes identified in solid tumors only. Variant selection was determined based on gene tumor-suppressor or oncogene status, known role in solid tumors versus hematological malignancies, and literature prevalence. The defined genes are *ASXL1, ATM, CBL, CHEK2, DNMT3A, IDH2, JAK2, KMT2D (MLL2), MPL, MYD88, SF3B1, TET2, and U2AF1* and are not inclusive of all CH genes. The content in this report should not substitute for dedicated hematological workup. Comprehensive genomic profiling of solid tumors detects nontumor alterations that are due to CH. Patient-matched peripheral blood mononuclear cell sequencing is required to conclusively determine if this alteration is present in tumor or is secondary to CH. Interpretation should be based on clinical context.

NATIONAL COMPREHENSIVE CANCER NETWORK® (NCCN®) CATEGORIZATION

Biomarker and genomic findings detected may be associated with certain entries within the NCCN Drugs & Biologics Compendium® (NCCN Compendium®) (www.nccn.org). The NCCN Categories of Evidence and Consensus indicated reflect the highest possible category for a given therapy in association with each biomarker or genomic finding. Please note, however, that the accuracy and applicability of these NCCN categories within a report may be impacted by the patient's clinical history, additional biomarker information, age, and/or co-occurring alterations. For additional information on the NCCN categories, please refer to the NCCN Compendium®. Referenced with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®). © National Comprehensive Cancer Network, Inc. 2023. All rights reserved. To view the most recent and complete version of the guidelines, go online to NCCN.org. NCCN makes no warranties of any kind whatsoever regarding their content, use or application and disclaims any responsibility for their application or use in any way.

LEVEL OF EVIDENCE NOT PROVIDED

Drugs with potential clinical benefit (or potential lack of clinical benefit) are not evaluated for source or level of published evidence.

NO GUARANTEE OF CLINICAL BENEFIT

This report makes no promises or guarantees that a particular drug will be effective in the treatment of

disease in any patient. This report also makes no promises or guarantees that a drug with potential lack of clinical benefit will in fact provide no clinical benefit.

NO GUARANTEE OF REIMBURSEMENT

Foundation Medicine makes no promises or guarantees that a healthcare provider, insurer or other third party payor, whether private or governmental, will reimburse a patient for the cost of FoundationOne Liquid CDx.

TREATMENT DECISIONS ARE THE RESPONSIBILITY OF PHYSICIAN

Drugs referenced in this Report may not be suitable for a particular patient. The selection of any, all or none of the drugs associated with potential clinical benefit (or potential lack of clinical benefit) resides entirely within the discretion of the treating physician. Indeed, the information in this Report must be considered in conjunction with all other relevant information regarding a particular patient, before the patient's treating physician recommends a course of treatment. Decisions on patient care and treatment must be based on the independent medical judgment of the treating physician, taking into consideration all applicable information concerning the patient's condition, such as patient and family history, physical examinations, information from other diagnostic tests, and patient preferences, in accordance with the standard of care in a given community. A treating physician's decisions should not be based on a single test, such as this test or the information contained in this report.

Certain sample of variant characteristics may result in reduced sensitivity. These include: low sample quality, deletions and insertions >40bp, or repetitive/high homology sequences. FoundationOne Liquid CDx is performed using cell-free DNA, and as such germline events may not be reported.

ORDERED TEST # ORD-1650540-01

APPENDIX

About FoundationOne®Liquid CDx

SELECT ABBREVIATIONS

ABBREVIATION	DEFINITION
CR	Complete response
DCR	Disease control rate
DNMT	DNA methyltransferase
HR	Hazard ratio
ITD	Internal tandem duplication
MMR	Mismatch repair
Muts/Mb	Mutations per megabase
NOS	Not otherwise specified
ORR	Objective response rate
OS	Overall survival
PD	Progressive disease
PFS	Progression-free survival
PR	Partial response
SD	Stable disease
TKI	Tyrosine kinase inhibitor

REFERENCE SEQUENCE INFORMATION

Sequence data is mapped to the human genome, Genome Reference Consortium Human Build 37 (GRCh37), also known as hg19.

MR Suite Version (RG) 7.10.0

ORDERED TEST # **ORD-1650540-01**
APPENDIX
References

1. Gandara DR, et al. Nat. Med. (2018) pmid: 30082870
2. Wang Z, et al. JAMA Oncol (2019) pmid: 30816954
3. Sturgill EG, et al. Oncologist (2022) pmid: 35274716
4. Aggarwal C, et al. Clin. Cancer Res. (2020) pmid: 32102950
5. Schenker et al., 2022; AACR Abstract CT022
6. Saori et al., 2021; ESMO Abstract 80P
7. Chen EX, et al. JAMA Oncol (2020) pmid: 32379280
8. Rizvi NA, et al. JAMA Oncol (2020) pmid: 32271377
9. Si H, et al. Clin Cancer Res (2021) pmid: 33355200
10. Leighl NB, et al. J Thorac Oncol (2022) pmid: 34800700
11. Li et al., 2020; ASCO Abstract 6511
12. Hu et al., 2017; ASCO Abstract e15791
13. Pfeifer GP, et al. Mutat. Res. (2005) pmid: 15748635
14. Hill VK, et al. Annu Rev Genomics Hum Genet (2013) pmid: 23875803
15. Pfeifer GP, et al. Oncogene (2002) pmid: 12379884
16. Rizvi NA, et al. Science (2015) pmid: 25765070
17. Johnson BE, et al. Science (2014) pmid: 24336570
18. Choi S, et al. Neuro-oncology (2018) pmid: 29452419
19. Cancer Genome Atlas Research Network, et al. Nature (2013) pmid: 23636398
20. Briggs S, et al. J. Pathol. (2013) pmid: 23447401
21. Heitzer E, et al. Curr. Opin. Genet. Dev. (2014) pmid: 24583393
22. Nature (2012) pmid: 22810696
23. Roberts SA, et al. Nat. Rev. Cancer (2014) pmid: 25568919
24. Bronkhorst AJ, et al. Biomol Detect Quantif (2019) pmid: 30923679
25. Raja R, et al. Clin. Cancer Res. (2018) pmid: 30093454
26. Hrebien S, et al. Ann. Oncol. (2019) pmid: 30860573
27. Choudhury AD, et al. JCI Insight (2018) pmid: 30385733
28. Goodall J, et al. Cancer Discov (2017) pmid: 28450425
29. Goldberg SB, et al. Clin. Cancer Res. (2018) pmid: 29330207
30. Bettegowda C, et al. Sci Transl Med (2014) pmid: 24553385
31. Lapin M, et al. J Transl Med (2018) pmid: 30400802
32. Shulman DS, et al. Br. J. Cancer (2018) pmid: 30131550
33. Stover DG, et al. J. Clin. Oncol. (2018) pmid: 29298117
34. Hemming ML, et al. JCO Precis Oncol (2019) pmid: 30793095
35. Egyud M, et al. Ann. Thorac. Surg. (2019) pmid: 31059681
36. Fan G, et al. PLoS ONE (2017) pmid: 28187169
37. Vu et al., 2020; DOI: 10.1200/P0.19.00204
38. Li G, et al. J Gastrointest Oncol (2019) pmid: 31602320
39. Zhang EW, et al. Cancer (2020) pmid: 32757294
40. Butler TM, et al. Cold Spring Harb Mol Case Stud (2019) pmid: 30833418