Test request form for patients with a diagnosis of cancer

Myriad Oncology

For lab use

- Make sure information is complete and legible
- Supply relevant documents such as insurance cards, clinical notes, and pathology reports

NOTE: Affix patient identifier label to specimen tube

Certain procedures may affect the results of this test Do not place an order using a blood or saliva sample for germline testing if the patient has had an allogeneic bone marrow or allogeneic stem cell transplant as the results would reflect the donor DNA profile. Please contact Myriad Medical Services: (800) 469-7423 x 3850 to discuss an alternative sample type. For patients who have had a whole blood transfusion, wait 28 days before collecting the sample. Please direct related questions to Myriad Medical Services: (800) 469-7423 x 3850.

For Medicare patients only

At the time of blood/saliva sample collection: ☐ Non-hospital patient ☐ Hospital outpatient ☐ Hospital inpatient (>24 hour stay) Discharge date: _____ (mm/dd/yyyy)

At the time of tumor sample collection: ☐ Non-hospital patient ☐ Hospital outpatient ☐ Hospital inpatient (>24 hour stay) Discharge date: _____ (mm/dd/yyyy)

1. Patient information (Complete information required.)

Legal name (last)	Legal name (first)	(m.i.)	Sex at birth ☐M ☐F	Birthdate (mm/dd/yyyy)	Patient ID #

Email (this enables us to contact the patient if there is an issue with their order or sample) ☐ I don't have the patient's email	Cell phone	Daytime phone

Address	City	State	Zip

2. Ordering provider information (Only name and HCP Account # required unless you're a new customer or HCP # is unknown.)

Name (last)	Name (first)	Myriad HCP account #	Degree	NPI #

Address	City	State	Zip

Office contact name	Phone	Fax	Email

3. Send results to (Optional - additional clinician can be listed to receive all test status updates and the patient's copy of the test results. Pathologists will immediately receive results.)

Name (last)	Name (first)	Myriad HCP account #	Degree	NPI #

Address	City	State	Zip

Office contact name	Phone	Fax	Email

4. Test requested Select all that apply (For test descriptions see page 3.)

Tests ordered will be processed and billed based on payer criteria. *When required by payer medical policy, MyRisk® Update may be performed as a reflex. *BRCA1* and *BRCA2* may be analyzed separately if required by payer.

Germline test options

For patients meeting hereditary breast and ovarian cancer syndrome criteria:

Select both tests if both analyses encompassing all available genes are desired

- ☐ **Integrated BRACAnalysis®** (*BRCA1* and *BRCA2* only. Not FDA approved.)
- ☐ **MyRisk® Hereditary Cancer Update Test** (does not include *BRCA1* and *BRCA2*. Not FDA approved.)

For patients meeting Lynch syndrome or *MYH*-associated polyposis (MAP) criteria:

Select both tests if both analyses encompassing all available genes are desired

- ☐ **COLARIS®PLUS** (*MLH1, MSH2, MSH6, PMS2, EPCAM,* and *MUTYH* only.)
- ☐ **MyRisk® Hereditary Cancer Update Test** (does not include Lynch genes *or MUTYH*.)

For patients meeting familial polyposis syndrome criteria:

Select both tests if both analyses encompassing all available genes are desired

- ☐ **COLARIS AP®PLUS** (*APC* and *MUTYH* only.)
- ☐ **MyRisk® Hereditary Cancer Update Test** (does not include *APC* or *MUTYH*.)

For patients previously tested at Myriad:

- ☐ **Myriad MyRisk® Update Test** (Available to patients who have been tested with BRACAnalysis®, COLARIS®, and/or COLARIS AP®. Full *BRCA1/2* duplication and deletion analysis and/or *PMS2* testing will be included in the test order unless previously performed or restricted by payor criteria.)

Tumor test options

Myriad HRD status test options (Select all that apply.)

- ☐ **MyChoice® CDx (FDA approved.)**
  - ☐ **Run as reflex after germline test,** only if *BRCA1* and *BRCA2* statuses are negative

Tumor molecular profiling options (Select all that apply.)

- ☐ **Precise Tumor®** (Not FDA approved.)
  - ☐ **Include PD-L1** (Not FDA approved.)

Additional testing options (Select all that apply.)

- ☐ **FOLR1/FRA testing (FDA approved.)**

5. Primary diagnosis of cancer currently being treated

Select applicable diagnosis (For additional personal cancer history, use Section 13 on page 4.)					Age at diagnosis	Clinical staging	Clinical status
☐ **Ovary** ☐ Left ☐ Right ☐ **Fallopian tube** ☐ Left ☐ Right ☐ **Peritoneum** (cul-de-sac, mesentery, mesocolon, omentum, parietal, pelvic)	☐ **Breast** (invasive): ☐ Left ☐ Right	For breast cancer: ER status: ☐+ ☐– PR status: ☐+ ☐– HER2 status: ☐+ ☐– High risk clinpath* ☐	☐ **Endometrial** ☐ **Colon** ☐ **Rectal** ☐ **Prostate** ☐ **Pancreatic**	☐ **Other** (specify): _____ _____		Early stage: ☐ I ☐ II Advanced stage: ☐ III ☐ IV	☐ Relapsed ☐ Refractory ☐ Metastatic ☐ Recurrent ☐ Other

*High-risk is defined as either 1) TNBC treated with either (a) adjuvant chemotherapy with axillary node-positive disease or an invasive primary tumor ≥2 cm on pathology analysis, or (b) neoadjuvant chemotherapy with residual invasive breast cancer in the breast or resected lymph nodes, or 2) hormone receptor positive disease treated with either (a) adjuvant chemotherapy with ≥4 positive pathologically confirmed lymph nodes, or (b) neoadjuvant chemotherapy which did not have a complete pathologic response, with a CPS+EG score of ≥3.

6. Authorized signature

I am licensed to order the selected test(s) and I have authorized this patient's order. I attest that the selected test(s) is medically necessary and that these results will be used in the medical management and treatment decisions for the above referenced patient. I agree to provide any additional information or documentation to support medical necessity, upon request. The patient has received genetic testing information and has consented to genetic testing, if required by state law. I authorize Myriad to assist the patient in obtaining pre-test genetic counseling services, if required by the patient's insurance provider.

Sign here: Medical professional (Required to process form) _____ Date: _____ (mm/dd/yyyy)
(Signature date is the specimen collection date if a different date is not provided above)

Myriad genetics®

Myriad Genetic Laboratories, Inc. / 322 North 2200 West, Salt Lake City, UT 84116 / (800)469-7423 / Fax (801) 883-8998 / myriad.com

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7. Patient information (Make sure information is the same as entered on page 1.)

Legal name (last)	Legal name (first)	Birthdate (mm/dd/yyyy)

Ancestry: (Select all that apply) ☐ Ashkenazi Jewish ☐ Asian ☐ Black / African ☐ Hispanic / Latino ☐ Middle Eastern ☐ Native American ☐ Pacific Islander ☐ White / Non-Hispanic

8. Family history of cancer

Provide complete and specific information to ensure proper insurance reimbursement, determine cancer risk estimates, and optimize medical management recommendations.

☐ **No known family history of cancer**

☐ **Limited family structure** Limited family history available such as fewer than two female† 1st- or 2nd-degree maternal or paternal relatives having lived beyond age 45.

If relative has not been tested, why?

Relationship to patient	Maternal (mother's side)	Paternal (father's side)	Cancer site, Gleason score, or polyp type (if colon/rectal adenomas, include total number)	Age at each diagnosis	Unavailable for testing	Relative is deceased	Patient has no contact with relative	Relative declines testing
	☐	☐			☐	☐	☐	☐
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	☐	☐			☐	☐	☐	☐

†Female refers to the sex assigned at birth with regard to relatives and breast cancer risk model information.

9. Specimen collection date

Blood/saliva sample collection date: ____________ (mm/dd/yyyy) **Tumor specimen collection date:** ____________ (mm/dd/yyyy)

10. Tumor specimen information (If tumor testing is not desired, proceed to section 11.)

Pathology report must be submitted with this test request form.

Tumor specimen

Tumor specimen identification number(s) *as it appears on the tissue block(s) or slides submitted to Myriad*:

Tissue type submitted:

Additional histopathology:

Ovarian tissue pathology*
☐ High-grade serous
☐ Non-epithelial
☐ Other
***Required for MyChoice® CDx test**

☐ **I authorize Myriad Genetic Laboratories, Inc. to request the specimen.** (Complete the information below.)

Pathology lab name		
Contact name	Phone	Fax

11. Billing/payment information

☐ **Option 1: Bill insurance:** (Please attach copy of authorization/referral)

Reminder: Include a copy of both sides of patient's insurance card(s).

If you submit more than one card, indicate which is primary.

Name of policy holder: ____________ Insurance ID#: ____________

DOB: ____________ (mm/dd/yyyy) Authorization/referral: ____________

Name of insurance: ____________ Patient relation to policy holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

I agree to the billing terms on reverse. Patient/responsible party signature: ____________ Sign here Date: ____________ (mm/dd/yyyy)

I understand that Myriad Genetics will contact me if I will be financially responsible for any non-covered service. To be considered for the Myriad Financial Assistance Program, please provide the following information: Annual household income: $ Number of family members in household:

☐ **Option 2: Uninsured** (Please call Customer Service for questions regarding test prices or for credit card payment.)

☐ **Option 3: Other billing** (To establish an account, submit billing information with this form.)

☐ Bill our institutional account #: or established research project code #: or Authorization/voucher #:

Please send completed forms via a secured pathway to OncologyPortfolio@myriad.com

Myriad genetics®

PA-1123-PC1

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Important information for patient

Billing terms

I represent that I am covered by insurance and authorize Myriad Genetic Laboratories, Inc. (MGL) to give my designated insurance carrier, health plan, or third party administrator (collectively "Plan") the relevant health information necessary for reimbursement. I authorize Plan benefits to be payable to MGL. I understand MGL will contact me if I will be financially responsible for any non-covered service. By agreeing to testing I also authorize Myriad to obtain a consumer credit report on me from a consumer reporting agency selected by Myriad. I understand and agree that Myriad may use my consumer credit report to confirm whether my income qualifies me for financial assistance. I further understand that this is not a credit application and will not impact my credit score. I agree to assist MGL in resolving insurance claim issues and if I don't assist, I may be responsible for the full test cost. I permit a copy of this authorization to be used in place of the original.

Affordability

For information about test affordability, please visit https://myriad.com/financial-assistance/.

Myriad also provides free language services to people whose primary language is not English through qualified interpreters. If you need these services, contact Customer Service at 800-469-7423.

Non-discrimination

Federal law (GINA) and laws in most states prohibit discrimination regarding employment eligibility, health benefits, or health insurance premiums based solely on genetic information. Myriad Genetic Laboratories, Inc. (Myriad) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Sex assigned at birth is a label given to an individual at birth, typically "male" or "female".

A legal name identifies a person for legal and administrative purposes. It is recorded on a birth certificate, marriage certificate, or other government issued document that records a name change.

Test descriptions (For a full list of tests offered, visit www.myriad.com/genetic-tests/)

Integrated BRACAnalysis®: Analysis of *BRCA1*, and *BRCA2* for susceptibility to Hereditary Breast and Ovarian Cancer syndrome.
Multisite 3 BRACAnalysis®: Three-mutation *BRCA1* and *BRCA2* analysis for individuals of Ashkenazi Jewish ancestry: BRCA1 c.68_69del (p.Glu23Valfs*17) (aka *BRCA1* 185delAG, 187delAG); *BRCA1* c.5266dupC (p.Gln1756Profs*74) (aka BRCA1 5382insC, 5385insC); *BRCA2* c.5946del (p.Ser1982Argfs*22) (aka BRCA2 6174delT).
COLARIS®PLUS: Analysis of *MLH1*, *MSH2*, *MSH6*, *PMS2*, *MUTYH*, and *EPCAM* for susceptibility to Lynch syndrome (HNPCC) and *MYH*-Associated Polyposis (MAP).
COLARIS AP®PLUS: Analysis of *APC* for susceptibility to FAP/AFAP.
Myriad MyRisk® Hereditary Cancer Update Test: Available to patients who have been tested with BRACAnalysis®, COLARIS®, and/or COLARIS AP®. Can be ordered as analysis of additional germline genes for patients tested with BRACAnalysis CDx® receiving a *BRCA1/2* status. Per payor medical policy, MyRisk Update may be performed as a reflex test.
MyChoice® CDx: Next generation sequencing-based *in vitro* diagnostic test that assesses the qualitative detection and classification of single nucleotide variants, insertions and deletions, and large rearrangement variants in protein coding regions and intron/exon boundaries of the *BRCA1* and *BRCA2* genes and the determination of Genomic Instability Score (GIS) which is an algorithmic measurement of Loss of Heterozygosity (LOH), Telomeric Allelic Imbalance (TAI), and Large-scale State Transitions (LST) using DNA isolated from formalin-fixed paraffin embedded (FFPE) tumor tissue specimens. The results of the test are used as an aid in identifying ovarian cancer patients with positive homologous recombination deficiency (HRD) status who are eligible, because of a positive test result for deleterious or suspected deleterious mutations in *BRCA1* or *BRCA2* genes, or may become eligible, because of a positive test result for deleterious or suspected deleterious mutations in *BRCA1* or *BRCA2* genes or a positive Genomic Instability Score, for treatment with the approved targeted therapy for LYNPARZA® (olaparib). In addition, detection of deleterious or suspected deleterious *BRCA1* and *BRCA2* mutations and/or positive Genomic Instability Score in ovarian cancer patients is also associated with enhanced progression-free survival (PFS) from ZEJULA® (niraparib) maintenance therapy in accordance with the most recently approved therapeutic product labeling. *When GIS is unable to be analyzed, tumor mutation *BRCA1/2* status alone may be reported.
Precise™ Tumor: A 523-gene, NGS comprehensive genomic profiling test using DNA and RNA to report key biomarkers such as Tumor Mutational Burden (TMB), Microsatellite Instability (MSI), fusions, and somatic mutations to help guide therapy eligibility for patients with solid tumors and identify potential clinical trial options. **PD-L1**: PD-L1 may identify patients eligible for immunotherapy in certain cancers as well as eligibility for enrollment in appropriate clinical trials. **Folate Receptor Alpha**: FOLR1/FRA is a qualitative immunohistochemical assay intended for use in the assessment of folate receptor alpha, FOLR1, in formalin-fixed, paraffin-embedded epithelial ovarian cancer specimens. This companion diagnostic test is used to aid in identifying adult patients with folate receptor-alpha positive, platinum-resistant epithelial ovarian, fallopian tube, or primary peritoneal cancer who are eligible for targeted treatment with mirvetuximab soravtansine-gynx/Elahere following one to three prior systemic treatment regimens.

Certain payers do not cover genetic testing when Single Nucleotide Polymorphisms (SNPs) are a component of the test. For payers who do not reimburse for a hereditary cancer test due to SNP analysis inclusion, Myriad will report the MyRisk Hereditary Cancer Test without SNPs.

To view the full list of genes available on the MyRisk® panel, please visit:
www.myriad.com/gene-table

The genes associated with MyRisk® Hereditary Cancer Panel are subject to change. To ensure you have a current version of the form please visit www.myriad.com/myrisk/documents-and-forms.

The MyRisk Management Tool and RiskScore may not be reported without an accurate and specific personal and family history included on the patient cancer family history. For the latest RiskScore® eligibility criteria, please visit Myriad's official technical specification webpage at: http://www.myriad.com/technical-specifications

RiskScore® and Tyrer-Cuzick model will not be calculated if provider indicates that they are not appropriate for the patient by selecting the check box in **Section 14**. Not all data collected on the form is incorporated into Tyrer-Cuzick or RiskScore® calculations. Some fields may be used for anonymized, internal validation studies only.

Turnaround time:
- The majority of MyRisk results are completed within 14 days
- We will notify you in the unusual event results take longer than 21 days

MyRisk® Report includes:
- MyRisk Genetic Result
- RiskScore® Result
  - Personalized breast cancer risk assessment based on an analysis of biomarkers combined with patient clinical and family history data
- MyRisk Management Tool
  - Guideline based (NCCN, CAPS, Amsterdam, and others) cancer management for both positive and negative results

Completing the test request form:
- Please include:
  - Age, cancer diagnosis, ancestry, gender, and cancer family history

Authorization of referral to genetic counseling

In signing **section 6** of the test request form, you hereby authorize Myriad to assist your patient in obtaining genetic counseling from a third-party service. The specific process will vary by third-party counseling service but in most situations the genetic counselor will be added as the healthcare provider receiving a copy of the patient's results, and also be allowed to change the test order should there be a clinical or payer-related reason to do so. You authorize the genetic counselor to facilitate the completion of any test requisition forms and/or submit any prior authorization, if necessary, on your behalf and identifying you as the ordering provider in any such forms by including your name and NPI.

Special instructions (if applicable): *Please note: some options may not be possible if an alternate is required by the patient's insurance or if the patient requests otherwise.

☐ Expedite genetic counseling for immediate management decision

☐ Maintain my test as ordered

☐ Allow me to review results with my patient prior to their follow-up counseling session

☐ Other: _____

Myriad Oncology

12. Patient information (Make sure information is the same as entered on page 1.)

Legal name (last)	Legal name (first)	Birthdate (mm/dd/yyyy)

13. Patient personal history of cancer & other clinical information (Select all that apply)

☐ **Patient has never been diagnosed with cancer**

Patient has been diagnosed with:	Age at diagnosis	Patient is currently being treated	Pathology /other info		
☐ **Breast cancer** ☐ Left ☐ Right (Primary diagnosis)		☐	☐ DCIS ☐ Ductal invasive ☐ Metastatic ☐ Lobular invasive ☐ High risk clinpath*	ER status: ☐ + ☐ − PR status: ☐ + ☐ − HER2 status: ☐ + ☐ −	**If ER/PR+, previous endocrine therapy:** ☐ Yes ☐ No ☐ N/A or inappropriate **Previous chemotherapy:** ☐ Yes ☐ No
☐ **Breast cancer** ☐ Left ☐ Right (Second primary diagnosis)		☐	☐ DCIS ☐ Ductal invasive ☐ Metastatic ☐ Lobular invasive ☐ High risk clinpath*	ER status: ☐ + ☐ − PR status: ☐ + ☐ − HER2 status: ☐ + ☐ −	**If ER/PR+, previous endocrine therapy:** ☐ Yes ☐ No ☐ N/A or inappropriate **Previous chemotherapy:** ☐ Yes ☐ No
☐ **Endometrial cancer - not sarcoma**		☐	☐ Tumor MSI-high or IHC abnormal - **result**: _____ ☐ Tumor not available for MSI or IHC testing		
Ovarian cancer (Select applicable diagnosis/es): ☐ **Ovary** ☐ Left ☐ Right ☐ **Fallopian tube** ☐ Left ☐ Right ☐ **Peritoneum** (cul-de-sac, mesentery, mesocolon, omentum, parietal, or pelvic)		☐	☐ Non-epithelial		
☐ **Prostate cancer**		☐	**Gleason score:** ☐ Metastatic (includes distant metastasis and regional bed/nodes) ☐ NCCN high / very high risk		
☐ **Colon cancer** ☐ **Rectal cancer**		☐	Type: ☐ Mucinous ☐ Signet ring ☐ Medullary growth pattern ☐ Tumor infiltrating lymphocytes ☐ Crohn's-like lymphocytic reaction ☐ Patient's tumor is MSI-high or IHC abnormal - **result**: _____ ☐ Tumor not available for MSI or IHC testing		
☐ **Colon adenomas** ☐ **Rectal adenomas**		☐	Number of cumulative adenomatous polyps: ☐ 1 ☐ 2-5 ☐ 6-9 ☐ 10-19 ☐ 20-99 ☐ 100+		
☐ **Hematologic cancer**		☐			
☐ **Pancreatic cancer**		☐			
☐ Other cancer		☐	Type:		

If applicable to patient: ☐ **Patient has received an allogeneic bone marrow or stem cell transplant**

If applicable to patient: **Predicted risk using a Lynch syndrome risk model (PREMM$_5$, MMRpro, or MMRpredict):** _____ **%**

*High-risk is defined as either 1) TNBC treated with either (a) adjuvant chemotherapy with axillary node-positive disease or an invasive primary tumor ≥2 cm on pathology analysis, or (b) neoadjuvant chemotherapy with residual invasive breast cancer in the breast or resected lymph nodes, or 2) hormone receptor positive disease treated with either (a) adjuvant chemotherapy with ≥4 positive pathologically confirmed lymph nodes, or (b) neoadjuvant chemotherapy which did not have a complete pathologic response, with a CPS+EG score of 3 or higher.

14. Breast cancer risk model options

Risk analysis options to be excluded from the report

☐ Do not include RiskScore® ☐ Do not include RiskScore® or Tyrer-Cuzick

15. Breast cancer risk model information Required for female patients only†. (If risk modeling is not desired, do not complete section 15.)

Patient information:

Height ft: in: **Weight** (lbs):

Patient's age at time of first menstrual period:

The patient is currently:
☐ Pre-menopausal
☐ Peri-menopausal
☐ Post-menopausal (**Age of post-menopausal onset:** _____)

Has this patient had a live birth?
☐ No
☐ Yes (**Patient's age at first child's birth:** _____)

Has patient ever used hormone replacement therapy? ☐ No ☐ Yes

If yes, treatment type: ☐ Combined ☐ Estrogen only ☐ Progesterone only

If yes, is patient a:
☐ **Current user:** Started _____ years ago, intended use for _____ more years
☐ **Past user:** Stopped _____ years ago

Information about patient's female relatives:

Number of daughters:

Number of sisters:

Number of maternal aunts: (mother's sisters)

Number of paternal aunts: (father's sisters)

Other information:

Mammographic Density:
Has the patient had her breast density assessed?
☐ No ☐ Yes

If yes, complete one of the following for the most recent assessment:

☐ Volpara® Volumetric Density: _____ %

☐ VAS Percentage Density: _____ %

☐ BI-RADS® ATLAS Density (Select one of the following):
- ☐ a. Almost entirely fatty
- ☐ b. Scattered fibroglandular density
- ☐ c. Heterogeneously dense
- ☐ d. Extremely dense
- ☐ Unknown

NOTE: Risk associated with mammographic density is incorporated into RiskScore (v.2), and Tyrer-Cuzick (v.8) calculations provided on the clinical report.

Please indicate if the patient has had a breast biopsy showing one or more of the following results:
☐ N/A (No biopsy or none of the listed results) ☐ Hyperplasia (not atypia) ☐ Atypical hyperplasia ☐ LCIS ☐ Biopsy with unknown or pending results

†Female refers to the sex assigned at birth with regard to relatives and breast cancer risk model information.