Precise™
Oncology Solutions

Test Request Form

For lab use

- Please submit both pages of this form
- Make sure information is complete and legible

NOTE: Affix patient identifier label to specimen tube

1. Patient information (Complete information required)

Name (last)	Name (first)	(m.i.)	Gender ☐ Male ☐ Female	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 both germline and tumor test status updates and the patient's copy of the test results.)

Note: Test results will automatically be sent to the pathologist providing the tumor specimen.)

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 4)

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 (Select up to one (1) BRACAnalysis® option)

☐ **BRACAnalysis CDx®** (FDA approved)
☐ **Myriad MyRisk® Hereditary Cancer Update Test*** (does not include *BRCA1* and *BRCA2*, see description on page 4. Not FDA approved.)

Or

☐ **Integrated BRCA*analysis*®** (*BRCA1* and *BRCA2* only. Not FDA approved)
☐ **Myriad MyRisk® Hereditary Cancer Update Test*** (does not include *BRCA1* and *BRCA2*, see description on page 4. Not FDA approved)

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)

NOTE: If ovarian tumor sample is insufficient to run multiple tests, Myriad Genetics will give order preference to MyChoice® CDx unless Precise™ Tumor is selected below:

☐ **Change preference to Precise™ Tumor**

5. Specimen information

Germline specimen

Blood/saliva sample collection date: _____ (mm/dd/yyyy) (**Note**: BRACAnalysis CDx® is only available as a blood test.)

For Medicare patients only — **At the time of sample collection:** ☐ Hospital outpatient ☐ Non-hospital patient ☐ Hospital inpatient (>24 hour stay) Discharge date: _____ (mm/dd/yyyy)
☐ My patient is not a Medicare patient

Tumor specimen

Tumor specimen collection date: _____ (mm/dd/yyyy)

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

_____

_____

Current diagnosis:

Stage:

Tissue type submitted:

Histopathology:

Patient is currently being treated	**Patient previously received treatment**
☐ None	☐ None
☐ Chemotherapy	☐ Chemotherapy
☐ Targeted therapy	☐ Targeted therapy
☐ Surgery	☐ Surgery
☐ Radiotherapy	☐ Radiotherapy
☐ Immunotherapy	☐ Immunotherapy

For Medicare patients only — **At the time of sample collection:** ☐ Hospital outpatient ☐ Non-hospital patient ☐ Hospital inpatient (>24 hour stay) Discharge date: _____
☐ My patient is not a Medicare patient

6. Specimen retrieval

Pathology report must be submitted with this test request form.

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

Pathology lab name	Contact Name	Phone	Fax

Myriad genetics

Myriad Genetic Laboratories, Inc. A CLIA Certified Laboratory
320 Wakara Way • Salt Lake City, UT 84108 / **(800) 469-7423** • **Fax (801) 883-8998** • myriad.com

PP-1221-PC1

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

Name (last)	(first)	(m.i.)	Birthdate (mm/dd/yyyy)

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

Patient has been diagnosed with:	Age at diagnosis	Patient is currently being treated	Pathology / other info		
Ovarian cancer (Select applicable diagnosis/es): ☐ **Left ovary** ☐ **Right ovary** ☐ **Left fallopian tube** ☐ **Right fallopian tube** ☐ **Peritoneum** (cul-de-sac, mesentery, mesocolon, omentum, parietal, pelvic)		☐	☐ Non-epithelial		
☐ **Breast cancer** ☐ **Left**		☐	☐ DCIS ☐ Invasive ductal ☐ Invasive lobular ☐ High risk clinpath*	ER status: ☐+ ☐– PR status: ☐+ ☐– HER2 status: ☐+ ☐–	**Previous chemotherapy:** ☐Yes ☐No **If ER/PR+, previous endocrine therapy:** ☐Yes ☐No ☐N/A or inappropriate
☐ **Breast cancer** ☐ **Right**		☐	☐ DCIS ☐ Invasive ductal ☐ Invasive lobular ☐ High risk clinpath*	ER status: ☐+ ☐– PR status: ☐+ ☐– HER2 status: ☐+ ☐–	**Previous chemotherapy:** ☐Yes ☐No **If ER/PR+, previous endocrine therapy:** ☐Yes ☐No ☐N/A or inappropriate
☐ **Endometrial cancer**		☐	☐ Tumor MSI-high or IHC abnormal - **Result:** _____ ☐ Tumor not available for MSI or IHC testing		
☐ **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**		☐	Cumulative adenomatous polyp #: ☐ 1 ☐ 2-5 ☐ 6-9 ☐ 10-19 ☐ 20-99 ☐ 100+		
☐ **Hematologic cancer**		☐	Type:		
☐ **Pancreatic cancer**		☐			
☐ **Prostate cancer**		☐	Gleason Score:	☐ Metastatic (includes distant metastasis and regional bed/nodes) ☐ NCCN high/very high risk	
☐ **Other cancer**		☐	Type:		
☐ **Other cancer**		☐	Type:		

Indicate if applicable to patient:

_____ % on one of the Lynch syndrome risk models (PREMM$_5$, MMRpro, or MMRpredict)

☐ Bone marrow transplant recipient **Type:** ☐ Autologous ☐ Allogeneic (If allogeneic please call 800-469-7423 x3850)

☐ Blood transfusion recipient within 28 days of sample collection **Type:** ☐ Whole blood ☐ Packed red blood cells

☐ Blood transfusion recipient within 12 months of sample collection **Date:** _____ (mm/dd/yyyy)

9. Ancestry (select all that apply)

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

10. 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

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
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		

*'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.

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

Name (last)	(first)	(m.i.)	Birthdate (mm/dd/yyyy)

12. Confirmation of informed consent & statement of medical necessity

I affirm each of the following: I have provided genetic testing information to the patient and the patient has consented to genetic testing and will accept financial responsibility. This test is medically necessary for the diagnosis of a disease or syndrome. The results will be used in the patient's medical management and treatment decisions. I authorize Myriad to assist my patient in obtaining pre-test genetic counseling services if required by the patient's insurance provider (see reverse). The person listed as the Ordering Provider is authorized by law to order the test(s) requested herein.

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)

13. Billing/payment information

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

Name of policy holder: _____

DOB: _____ / _____ / _____ (mm/dd/yyyy)

If your patient is interested in learning about the **Myriad Financial Assistance Program**, ask them to visit:
https://myriad.com/about-myriad/myriad-cares-2/financial-assistance-program/

Name of insurance: _____

Insurance ID#: _____

Authorization/referral: _____

Patient relation to policy holder:

☐ Self ☐ Spouse ☐ Child ☐ Other

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

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

☐ **Option 2: Patient payment** (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 #:

Additional notes / instructions

Important information for provider

The interpretation of the germline test(s) may be impacted if the patient has had an alllogeneic bone marrow transplant or a hematologic malignancy. The interpretation of the tumor test(s) may be impacted if the patient has had an allogeneic bone marrow transplant.

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.

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.

Affordability: Myriad Promise™

- The majority of appropriate patients pay $0
- Myriad will work with your insurance provider to help you get the appropriate coverage
- The Myriad Promise is our commitment to provide patients with accurate and affordable genetic results
- For more information please refer to the billing information at MyriadPromise.com

†Translation of Billing Terms are available in Mandarin and Spanish at myriadpromise.com. 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.

Test descriptions (For a full list of tests offered, visit www.myriadmyrisk.com.)

Integrated BRAC*Analysis*®: Analysis of *BRCA1*, and *BRCA2* for susceptibility to Hereditary Breast and Ovarian Cancer syndrome.
Myriad MyRisk® Hereditary Cancer Update Test: Available to patients who have been tested with BRAC*Analysis*®, 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.
BRACAnalysis CDx®: *BRCA1* and *BRCA2* gene sequence and large rearrangement analyses to identify the presence of *BRCA1/2* mutation(s). Results of the test are used as an aid in identifying breast cancer patients who are or may become eligible for treatment with Lynparza® (olaparib) or Talzenna® (talazoparib). In addition, results of the test are used as an aid in identifying ovarian cancer patients who are or may become eligible for treatment [treatment/maintenance] with Lynparza® (olaparib) or Rubraca® (rucaparib). A positive BRACAnalysis CDx result in ovarian cancer patients is also associated with enhanced progression-free survival (PFS) from Zejula® (niraparib) or with Rubraca® (rucaparib) maintenance therapy. Results of the test are also used for pancreatic and prostate cancer patients who are or may become eligible for treatment with Lynparza® (olaparib).
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 Zejula® (niraparib) or 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. *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.

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

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

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

Completing the test request form:

- Please include:
  - Age, cancer diagnosis, ancestry, gender, and cancer family history

For additional information visit
www.mysupport360.com and www.myriadmyrisk.com

Authorization of referral to genetic counseling

In signing **section 13** 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: _____