BRACAnalysis CDx®

Germline Companion Diagnostic Test

MyRisk®

Hereditary Cancer Test

Test Request Form

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

For lab use

Specimen collection date (required)

(mm/dd/yyyy)

Note: Affix patient identifier label to specimen tube

At the time of specimen collection: ☐ Hospital outpatient ☐ Non-hospital patient ☐ Hospital inpatient (>24 hour stay) Discharge date:

1. Patient information (Complete information required)

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

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 test status updates and the patient's copy of the test results)

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

Address	City	State	Zip

Office contact name	Phone	Fax	Email

4. Test requested (For test descriptions see reverse)

Tests ordered will be processed and billed based on payer criteria.

☐ **BRACAnalysis CDx® -** *BRCA1* and *BRCA2* gene sequence and large rearrangement analysis 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 with LYNPARZA® (olaparib) or ZEJULA® (niraparib). In addition, results of the test are also used for pancreatic and prostate cancer patients who are or may become eligible for treatment with LYNPARZA® (olaparib). For more detailed information, including a complete list of Contraindications, Limitations, Warnings and Precautions of the assay, please see page 2 of the Technical Information at: https://s3.amazonaws.com/myriad-web/BRACAnalysisCDxTS.pdf.

☐ **Myriad Genetics MyRisk® Hereditary Cancer Update Test -** (Available to patients who have been tested with BRACAnalysis®, COLARIS®, and/or COLARIS AP®. Analysis of additional germline genes for patients tested with BRACAnalysis CDx® receiving a *BRCA1/2* status. Per payor medical policy, MyRisk Update Test may be performed as a reflex test.)

5. 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. 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 Genetics to assist my patients 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) X _____ Date: _____ (mm/dd/yyyy)

(Signature date is the specimen collection date if a different date is not provided above)

6. Billing/payment information

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

Name of policy holder: _____

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

Sign here: Patient/responsible party I agree to the billing terms on reverse X _____

Name of insurance: _____

Insurance ID#: _____

Authorization/referral: _____

Patient relation to policy holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

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

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

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: 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 #:

Myriad genetics

Myriad Genetic Laboratories, Inc. A CLIA Certified Laboratory
320 Wakara Way • Salt Lake City, UT 84108 / **(800) 469-7423 • Fax (801) 584-3615** • myriad.com

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Testing for BRACAnalysis CDx®

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/)

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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 TRF please visit www.myriad.com/myrisk/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

Authorization of referral to genetic counseling

In signing **section 5** 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: _____

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

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

8. Ancestry

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

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

☐ **No personal history of cancer**

Patient has been diagnosed with:	Age at diagnosis	Patient is currently being treated	Pathology / other info		
☐ **Breast cancer** (Primary diagnosis) ☐ Left ☐ Right		☐	☐ 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** (Second primary diagnosis) ☐ Left ☐ Right		☐	☐ 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
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		
☐ 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:		

Check if applicable to patient:

- ☐ **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)
- ☐ **Diagnosis of a hematologic cancer** **Type:**

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

11. Breast cancer risk model information

Only complete for female patients never diagnosed with breast cancer

Patient information:

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

Patient's age at time of first menstrual period:

Is patient 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

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