BRACAnalysis®

Powered by myVision

FOR LAB USE

SPECIMEN COLLECTION DATE (REQUIRED)

Test Request Form and Statement of Medical Necessity

TO AVOID DELAYS PLEASE COMPLETE ENTIRE FORM

NOTE: Affix Bar Code Label to Specimen Tube

AT THE TIME OF SPECIMEN COLLECTION: ☐ Hospital Inpatient (>24 hour stay) Discharge date: ______________________ (MM/DD/YYYY) ☐ Hospital Outpatient ☐ Non-Hospital Patient

PATIENT INFORMATION (Complete information required)

Name (last, first, middle initial)		Gender ☐ MALE ☐ FEMALE	Birthdate (MM/DD/YYYY)	Patient ID#	Email
Address	City	State	Zip	Cell phone	Daytime phone

ORDERING PHYSICIAN INFORMATION (Only Name and HCP# are required unless you are a new customer or HCP# is unknown)

Name (last, first)		Myriad HCP Account #	Degree	NPI#
Address		City	State	Zip
Office Contact Name	Phone	Fax	Email	

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, first)		Myriad HCP Account #	Degree	NPI#
Address		City	State	Zip
Office Contact Name	Phone	Fax	Email	

PATIENT ANCESTRY (Select all that apply)

☐ White / Non-Hispanic ☐ Black / African ☐ Asian ☐ Pacific Islander ☐ Other
☐ Hispanic / Latino ☐ Ashkenazi Jewish ☐ Native American ☐ Middle Eastern ______________

PATIENT PERSONAL HISTORY OF CANCER & OTHER CLINICAL INFORMATION (Select all that apply)

☐ No personal history of cancer

PATIENT DIAGNOSED WITH:	AGE at Dx	PATIENT IS CURRENTLY BEING TREATED	PATHOLOGY / OTHER INFO
☐ Breast Cancer ☐ L ☐ R		☐	☐ Ductal Invasive ☐ DCIS ☐ Triple Negative (ER-, PR-, HER2-) ☐ Lobular Invasive ☐ Bilateral ☐ Metastatic HER2 Status: ☐ + ☐ – Previous Chemotherapy: ☐ Yes ☐ No If ER/PR+, previous Endocrine Therapy: ☐ Yes ☐ No ☐ N/A or inappropriate
☐ Ovarian		☐	☐ Non-epithelial
☐ Prostate		☐	Gleason Score: ________ ☐ Metastatic (includes distant metastasis and regional bed/nodes) ☐ NCCN High / Very High Risk
☐ Hematologic Cancer		☐	
☐ 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
☐ Blood Transfusion recipient within 12 months of sample collection
Type: ☐ Whole blood ☐ Packed red blood cells
Date: ______________ (MM/DD/YYYY)

FAMILY HISTORY OF CANCER (Please Indicate Relationship, Maternal or Paternal, Site of Cancer, Age at Diagnosis) (Please Indicate if Bilateral, Premenopausal, or Triple Negative Breast Cancer)

☐ No known family history

RELATION TO PATIENT	MATERNAL	PATERNAL	CANCER SITE	AGE(s) at Dx	RELATION TO PATIENT	MATERNAL	PATERNAL	CANCER SITE	AGE(s) at Dx
	☐	☐				☐	☐		
	☐	☐				☐	☐		

☐ **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

TESTS REQUESTED

☐ **Integrated BRAC*Analysis*** – *BRCA1* and *BRCA2* gene sequence and large rearrangement analysis for susceptibility to Hereditary Breast and Ovarian Cancer syndrome (Large rearrangement analysis may be reported and billed independently, and insurance coverage may vary based on payor criteria; certain payors may require reflex testing.)

☐ **Multisite 3 BRAC*Analysis*** – Three-mutation *BRCA1* and *BRCA2* analysis for individuals of Ashkenazi Jewish ancestry (187delAG, 5385insC, 6174delT)
☐ REFLEX to Integrated BRAC*Analysis* if the Multisite 3 is negative ☐ Check here if a family member has tested positive for one of the above three mutations.

☐ **Single Site BRAC*Analysis*** – Mutation-specific analysis for individuals with known *BRCA1* or *BRCA2* mutations in their family
Specify Gene: ☐ *BRCA1* ☐ *BRCA2* **Specify Variant** (Mutation): ______________________.
Relationship: My patient is the ______________________ (e.g., maternal aunt) of the known mutation carrier. Required: Include a copy of the known mutation carrier's report.

☐ **Other:** ______________________

CONFIRMATION OF INFORMED CONSENT AND 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. The person listed as the Ordering Physician is authorized by law to order the test(s) requested herein.

Medical Professional Signature: ______________________ SIGN HERE DATE: ______________ (MM/DD/YYYY)
(NOTE: Test requests without a signature will not be processed) (Signature date is the specimen collection date if a different date is not provided above)

BILLING/PAYMENT INFORMATION

☐ OPTION 1: PLEASE BILL MY INSURANCE (Option 1 requires patient signature and enlarged copy of both sides of insurance card(s). If more than one card is submitted, indicate which is primary)

Name of Policy Holder: ______________________ DOB: ______________ Insurance ID #: ______________ (Please attach copy of authorization/referral)
Patient Relation to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other Authorization/Referral #: ______________

I AGREE TO THE BILLING TERMS ON REVERSE Patient/Responsible Party Signature: ______________________ SIGN HERE DATE: ______________ (MM/DD/YYYY)

I understand that Myriad 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 ______________.

REMINDER: INCLUDE A COPY OF BOTH SIDES OF YOUR INSURANCE CARD(S)

☐ 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 #: ______________

MGBTRF/07-2019 Myriad, the Myriad logo, BRACAnalysis, the BRACAnalysis logo, myVision and the myVision logo are either trademarks or registered trademarks of Myriad Genetics, Inc., in the United States and other jurisdictions. ©2019 PB 176 Rev 1

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
- If you encounter ANY financial hardship associated with your bill, Myriad will work with you toward your complete satisfaction
- 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.