Colaris®AP

Hereditary Cancer Test

Test Request Form

A test for the polyposis syndromes (FAP, AFAP, MAP)

- 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: ☐ 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	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)

Testing for Lynch syndrome (HNPCC) and *MYH*-associated polyposis (MAP)

☐ **COLARIS AP®PLUS** – Analysis of *APC* and *MYH*

Other tests

☐ **Single Site testing** – Mutation-specific analysis for individuals with known mutations in their family.

Specify gene: _____ **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 carriers report.

☐ **Other:**

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 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 _____

(Signature date is the specimen collection date if a different date is not provided here) Date: _____ (mm/dd/yyyy)

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 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 #: _____

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 COLARIS AP®PLUS

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.

^Translation of Billing Terms are available in Mandarin and Spanish at www.**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.

Affordability: Myriad Promise™

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

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.

COLARIS AP®

A genetic test for adenomatous polyposis syndromes [including familial adenomatous polyposis (FAP), attenuated FAP, and MYH-associated polyposis (MAP)]

COLARIS AP®PLUS:
Full sequence and large rearrangement analysis of *APC* and *MYH*

Single Site Polyposis Testing:
Mutation-specific analysis for individuals with a known *APC* or *MYH* mutation(s) in the family

Gene-Specific COLARIS AP®:
APC gene analysis – Full sequence and large rearrangement analysis of *APC*
MYH gene analysis – Full sequence and large rearrangement analysis of *MYH*

NOTE: If COLARIS®PLUS and COLARIS AP®PLUS are ordered on the same patient, *MYH* analysis will only be performed once.

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)	(m.i.)	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)

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

Patient has been diagnosed with:	Age at diagnosis	Patient is currently being treated	Pathology /other info
☐ 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+
☐ Endometrial cancer - not sarcoma		☐	☐ Tumor MSI-high or IHC abnormal - **result:** _____ ☐ Tumor not available for MSI or IHC testing
☐ Prostate cancer		☐	**Gleason score:** ☐ Metastatic (includes distant metastasis and regional bed/nodes) ☐ NCCN high / very high risk
☐ Hematologic cancer		☐	
☐ Other cancer		☐	Type:
☐ ICD-10 code(s)/Dx:			

Check 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)

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**

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	If relative has not been tested, why? Relative is deceased	Patient has no contact with relative	Relative declines testing
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