myriad®

EndoPredict®

TEST REQUEST FORM

TO AVOID DELAYS PLEASE COMPLETE ENTIRE FORM

MYRIAD GENETIC LABORATORIES, INC.
320 Wakara Way • Salt Lake City, Utah 84108
Phone: (844) 887-3636 | Fax: (801) 583-8248
Email: EndoPredict@Myriad.com

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, INITIAL)

PATIENT ID # (OPTIONAL) ○ FEMALE ○ MALE BIRTH DATE (MM/DD/YYYY)

STREET ADDRESS

CITY STATE ZIP

DAYTIME PHONE NUMBER

E-MAIL

ORDERING PHYSICIAN (Only fill out first line unless new customer or HCP# is unknown)

NAME (LAST, FIRST, DEGREE) **MYRIAD HCP ACCOUNT NO: (If known)**

NPI # E-MAIL ADDRESS

ADDRESS

CITY STATE ZIP

OFFICE CONTACT PHONE FAX

EMAIL

CLINICAL INFORMATION

○ Invasive breast cancer Age at Dx: _____ Surgery Date: _____

Tumor Stage: ○ pT1a (>0.1 cm but ≤0.5 cm) ○ pT1b (>0.5 cm but ≤1 cm) ○ pT1c (>1 cm but ≤2 cm) ○ pT2 (>2 cm but ≤5 cm) ○ pT3 (>5 cm)

Lymph node status: ○ pN0 (zero positive nodes) ○ pN1a (1-3 positive nodes) ○ pN1mi (>0.2 mm and/or >200 cells but <2mm)

For Medicare Patients Only:

At the time of procedure: ○ Hospital Inpatient (>24 hour stay) Discharge Date: _____ ○ Hospital Outpatient ○ Non-Hospital Patient

TEST REQUESTED

EndoPredict - a gene expression test to determine the likelihood of distant cancer recurrence up to 10 years after invasive breast cancer diagnosis. EndoPredict is validated for patients with resected ER+, HER2- invasive female breast cancer that has NOT been treated prior to resection with neo-adjuvant therapy (e.g., chemotherapy, radiation therapy or endocrine therapy) and are under consideration for adjuvant chemotherapy. The EndoPredict test result has not been validated for patients not meeting these specific inclusion criteria.

SPECIMEN INFORMATION

Sample Fixative: (check one): ○ 10% neutral buffered formalin ○ Other (describe): _____

Tissue Type Submitted (e.g., Breast): _____

# of Block(s): _____ # of Slide(s): _____

Date Specimen Retrieved from Archive: _____

Specimen Identification Number as it appears on the tissue block(s) or slides submitted to Myriad:

_____ _____

_____ _____

_____ _____

_____ _____

SPECIMEN RETRIEVAL

○ I want Myriad Genetic Laboratories, Inc. to request the specimen. (COMPLETE the information below.)

_____

LOCATION OF SPECIMEN PHONE FAX CONTACT NAME

AUTHORIZED SIGNATURE

I hereby authorize testing and confirm that informed consent has been obtained, if required by state law. I hereby attest that the person listed in the Ordering Physician space above is authorized by law in the relevant jurisdiction to order the test(s) requested herein. By signing this form I attest that the patient meets the inclusion criteria stated in the Test Requested section above.

_____

HEALTHCARE PROVIDER'S SIGNATURE DATE

BILLING/PAYMENT INFORMATION

○ **OPTION 1: PLEASE BILL INSURANCE** (For Medicare patients: only available if test order date is more than 2 weeks after discharge date)

Include enlarged copies of both sides of insurance card(s). If two cards are submitted, indicate which is primary.

○ **OPTION 2: PATIENT PAYMENT** (Please call Customer Service for questions regarding test prices)

○ **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 #: _____