THIS TEST IS INAPPROPRIATE FOR TISSUE THAT HAS BEEN PREVIOUSLY TREATED WITH SYSTEMIC THERAPY (E.G. CHEMOTHERAPY, RADIATION THERAPY, OR ENDOCRINE THERAPY.) *Refer to the Test Requested section for more detail regarding patient eligibility.

myriad®

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

EndoPredict®

TEST REQUEST FORM

TO AVOID DELAYS PLEASE COMPLETE ENTIRE FORM

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, INITIAL)

PATIENT ID # (OPTIONAL) | BIRTH DATE (MM/DD/YYYY)

☐ FEMALE ☐ MALE

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: _____ Procedure (surgery or biopsy) Date: _____ (MM/DD/YYYY)

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) ☐ pTx

Lymph Node Status: ☐ pN0 (zero positive nodes) ☐ pN1 (1-3 positive nodes; excluding pNmi) ☐ pN1mi (>0.2 mm and/or >200 cells but <2mm) ☐ pNx

FOR MEDICARE PATIENTS ONLY:

At the time of procedure: ☐ Hospital Inpatient (>24 hour stay) Discharge Date: _____ (MM/DD/YYYY) ☐ Hospital Outpatient ☐ Non-Hospital Patient

PATIENT TREATMENT PLAN

☐ Patient is a candidate for adjuvant chemotherapy
☐ Patient is a candidate for extended endocrine therapy
☐ Patient is CURRENTLY RECEIVING or HAS RECEIVED neoadjuvant treatment (e.g. chemotherapy, radiation therapy, or endocrine therapy)

TEST REQUESTED

EndoPredict - a next-generation breast cancer recurrence test that integrates tumor biology and pathology to accurately predict individualized early (0-10 year) and late (5-15 year) distant recurrence after 5 years of endocrine therapy, and an absolute chemotherapy benefit. The test provides a 12-Gene Molecular Score. This is combined with pathologic tumor size and nodal status to calculate an EPclin Risk Score. The risks of early and late distant recurrence with 5 years of adjuvant endocrine therapy alone, and the estimated absolute benefit of chemotherapy are determined from the EPclin Risk Score. Recurrence risk and chemotherapy benefit estimates are based on the analysis of cohorts of women with ER+/HER2– invasive female breast cancer who have NOT been treated prior to resection with systemic neo-adjuvant therapy (e.g., chemotherapy, radiation, or endocrine therapy), who do not have multiple primary breast cancer, who do not have a prior diagnosis of breast cancer, and who do not have a current or prior diagnosis of an additional cancer. Risks may differ for individuals who do not meet the aforementioned clinical characteristics. This test is not appropriate for patients who do not meet the aforementioned clinical characteristics or who have already experienced a distant recurrence.

SPECIMEN INFORMATION

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

Tissue Type Submitted: ☐ Breast Resection (preferred) ☐ Breast Biopsy

Date Specimen Retrieved from Archive: _____ (MM/DD/YYYY)

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. Individual and treating physician have had a discussion prior to testing regarding the potential results of the test and determined to use the results to guide therapy.

HEALTHCARE PROVIDER'S SIGNATURE | DATE (MM/DD/YYYY)

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 #: _____

PP-0321-EP1

How to Order an EndoPredict® Test

EndoPredict®

1. COMPLETE THE FOLLOWING SECTIONS ON THE TRF:

(Identified by darker shaded bar)

- ☐ Patient Information
  - *Name, birthdate and demographics sheet, OR complete ALL fields*
- ☐ Ordering Physician Information
- ☐ Patient Treatment Plan
- ☐ Specimen Retrieval
  - *Pathology information (name, fax, phone, contact person)*
  - *Send TRF to pathology lab to initiate tissue processing*
  - *NOTE: Specimen must be **formalin-fixed paraffin embedded***
- ☐ Authorized Signature and Date

2. ATTACH THE FOLLOWING:

- ☐ Demographic Sheet
- ☐ Copy of Insurance Card
- ☐ Pathology Report

3. After sending the TRF to the pathology lab to initiate tissue processing, EMAIL THE TRF AND DOCUMENTS TO:

EndoPredict@myriad.com or fax forms to: **801-583-8248**

4. SIGN UP to receive electronic results at: www.MyriadPro.com

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.