myriad®

MYRIAD myChoice® CDx

MYRIAD GENETIC LABORATORIES, INC.
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Test Request Form

TO AVOID DELAYS PLEASE COMPLETE ENTIRE FORM

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 ADDRESS

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

NAME (LAST, FIRST, DEGREE) | MYRIAD HCP ACCOUNT #

NPI # | E-MAIL ADDRESS

ADDRESS

CITY | STATE | ZIP

OFFICE CONTACT | PHONE | FAX

EMAIL

CLINICAL INFORMATION

☐ Ovarian Cancer (Ovary, Fallopian Tube, Peritoneum) Age at Dx: _____

Date of Biopsy or Surgery: _____ (MM/DD/YYYY)

FOR MEDICARE PATIENTS ONLY:

At the time of biopsy or surgery:

☐ Hospital Inpatient (>24 hour stay) Discharge Date: _____ (MM/DD/YYYY)

☐ Hospital Outpatient ☐ Non-Hospital Patient

TEST REQUESTED

☐ Myriad **myChoice® CDx** - Next generation sequencing-based *in vitro* diagnostic test that assesses the qualitative detection and classification of single nucleotide variants, insertions and deletions, and large rearrangement variants in protein coding regions and intron/exon boundaries of the *BRCA1* and *BRCA2* genes and the determination of Genomic Instability Score (GIS) which is an algorithmic measurement of Loss of Heterozygosity (LOH), Telomeric Allelic Imbalance (TAI), and Large-scale State Transitions (LST) using DNA isolated from formalin-fixed paraffin embedded (FFPE) tumor tissue specimens. The results of the test are used as an aid in identifying ovarian cancer patients with positive homologous recombination deficiency (HRD) status who are eligible, because of a positive test result for deleterious or suspected deleterious mutations in *BRCA1* or *BRCA2* genes, or may become eligible, because of a positive test result for deleterious or suspected deleterious mutations in *BRCA1* or *BRCA2* genes or a positive Genomic Instability Score for treatment with the approved targeted therapy for Zejula® (niraparib).

SPECIMEN INFORMATION

Sample Fixative: (check one): ☐ Fixed tissue ☐ Other (describe): _____

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

# 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.

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 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 #: _____

Testing for Myriad myChoice® 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.

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,