MyRisk®

Hereditary Cancer Test

Test Request Form

- 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)

Tests ordered will be processed and billed based on payer criteria.
***When required by payer medical policy, MyRisk® Update may be performed as a reflex. *BRCA1* and *BRCA2* may be analyzed separately if required by payer.**

Germline test options:

For patients meeting hereditary breast and ovarian cancer syndrome criteria:

Select both tests if both analyses encompassing all available genes are desired

- ☐ **Integrated BRACAnalysis®** (*BRCA1* and *BRCA2* only)*
- ☐ **Myriad MyRisk® Update Test** (does not include *BRCA1* and *BRCA2*, see description on reverse)

For patients meeting Lynch syndrome or *MYH*-associated polyposis (MAP) criteria:

Select both tests if both analyses encompassing all available genes are desired

- ☐ **COLARIS®PLUS** (*MLH1, MSH2, MSH6, PMS2, EPCAM,* and *MUTYH* only)
- ☐ **Myriad MyRisk® Update Test*** (does not include Lynch genes *or MUTYH*, see description on reverse)

For patients meeting familial polyposis syndrome criteria:

Select both tests if both analyses encompassing all available genes are desired

- ☐ **COLARIS AP®PLUS** (*APC* and *MUTYH* only)
- ☐ **Myriad MyRisk® Update Test*** (does not include *APC* or *MUTYH*, see description on reverse)

For patients of Ashkenazi Jewish ancestry:

- ☐ **MultiSite 3 BRACAnalysis®**

Select both tests if both analyses encompassing all available genes are desired

- ☐ **REFLEX to Integrated BRACAnalysis®PLUS** (*BRCA1* and *BRCA2* only)
- ☐ **REFLEX to Myriad MyRisk® Update Test*** (does not include *BRCA1*, *BRCA2*, see description on reverse)

For patients previously tested at Myriad:

- ☐ **Myriad MyRisk® Update Test** (Available to patients who have been tested with BRACAnalysis®, COLARIS®, and/or COLARIS AP®. Full *BRCA1/2* duplication and deletion analysis and/or *PMS2* testing will be included in the test order unless previously performed or restricted by payor criteria.)

Risk analysis options (to be excluded on report, see reverse for details):

- ☐ Do not include RiskScore®
- ☐ Do not include RiskScore® or Tyrer-Cuzick

Additional tests and patient follow up:

- ☐ **Single Site testing:** specify gene: _____ and 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.**

- ☐ **RNA analysis:** Contact my patient if they become eligible for complimentary RNA studies which may help classify certain variants found in their analysis.
- ☐ **Other:** (e.g. single gene analysis)

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

PP-0323-MR1

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Testing for Myriad MyRisk® Hereditary Cancer

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.

Affordability

For information about test affordability, please visit https://myriad.com/financial-assistance/.

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.

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.

Test descriptions (For a full list of tests offered, visit www.myriad.com/genetic-tests/)

Integrated BRACAnalysis®: Analysis of *BRCA1*, and *BRCA2* for susceptibility to Hereditary Breast and Ovarian Cancer syndrome.
MultiSite 3 BRACAnalysis®: Three-mutation *BRCA1* and *BRCA2* analysis for individuals of Ashkenazi Jewish ancestry: BRCA1 c.68_69del (p.Glu23Valfs*17) (aka *BRCA1* 185delAG, 187delAG); *BRCA1* c.5266dupC (p.Gln1756Profs*74) (aka BRCA1 5382insC, 5385insC); *BRCA2* c.5946del (p.Ser1982Argfs*22) (aka BRCA2 6174delT).
COLARIS®PLUS: Analysis of *MLH1*, *MSH2*, *MSH6*, *PMS2*, *MUTYH*, and *EPCAM* for susceptibility to Lynch syndrome (HNPCC) and *MYH*-Associated Polyposis (MAP).
COLARIS AP®PLUS: Analysis of *APC* for susceptibility to FAP/AFAP.
Single Site Testing: Analysis for detection of a familial mutation. Report will indicate the presence or absence of mutation, along with any incidental reportable variants identified on the gene.
Myriad MyRisk® Update Test: Analysis of additional hereditary cancer genes for patients who have been tested with BRAC*Analysis*®, COLARIS®, and/or COLARIS AP®. Full *BRCA1/2* duplication and deletion analysis and/or *PMS2* testing will be included in the test order unless previously performed or restricted by payor criteria. When required by medical policy, MyRisk Update may be performed as a reflex with genes from the original testing excluded.

To view the full list of genes available on the MyRisk® panel, please visit: www.myriad.com/gene-table

The genes associated with MyRisk® Hereditary Cancer Panel are subject to change. To ensure you have a current version of the TRF please visit www.myriad.com/myrisk/documents-and-forms.

The MyRisk Management Tool and RiskScore may not be reported without an accurate and specific personal and family history included on the patient cancer family history in **sections 7 - 11**.

For the latest RiskScore® eligibility criteria, please visit Myriad's official technical specification webpage at: http://www.myriad.com/technical-specifications.

RiskScore® and Tyrer-Cuzick model will not be calculated if provider indicates that they are not appropriate for the patient by selecting the check box in **section 4**. Not all data collected on the TRF is incorporated into Tyrer-Cuzick or RiskScore® calculations. Some fields may be used for anonymized, internal validation studies only.

Certain payers do not cover genetic testing when Single Nucleotide Polymorphisms (SNPs) are a component of the test. For payers who do not reimburse for a hereditary cancer test due to SNP analysis inclusion, Myriad will report the MyRisk Hereditary Cancer Test without SNPs and these patients will not receive a SNP based RiskScore®.

Turnaround time:

- The majority of MyRisk® results are completed within 14 days
- We will notify you in the unusual event results take longer than 21 days

MyRisk® Report includes:

- MyRisk Genetic Result
- RiskScore® Result
  - Personalized breast cancer risk assessment based on an analysis of biomarkers combined with patient clinical and family history data
- MyRisk Management Tool
  - Guideline based (NCCN, CAPS, Amsterdam, and others) cancer management for both positive and negative results
  - Includes a Tyrer-Cuzick breast cancer risk estimate

Completing the test request form:

- Please include:
  - Age, cancer diagnosis, ancestry, sex at birth, and cancer family history

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
☐ Breast cancer (Primary diagnosis) ☐ Left ☐ Right		☐	☐ DCIS ☐ Ductal invasive ☐ Metastatic ☐ Lobular invasive ☐ High risk clinpath* ER status: ☐+ ☐– PR status: ☐+ ☐– HER2 status: ☐+ ☐– **If ER/PR+, previous endocrine therapy:** ☐ Yes ☐ No ☐ N/A or inappropriate **Previous chemotherapy:** ☐ Yes ☐ No
☐ Breast cancer (Second primary diagnosis) ☐ Left ☐ Right		☐	☐ DCIS ☐ Ductal invasive ☐ Metastatic ☐ Lobular invasive ☐ High risk clinpath* ER status: ☐+ ☐– PR status: ☐+ ☐– HER2 status: ☐+ ☐– **If ER/PR+, previous endocrine therapy:** ☐ Yes ☐ No ☐ N/A or inappropriate **Previous chemotherapy:** ☐ Yes ☐ No
☐ Endometrial cancer - not sarcoma		☐	☐ Tumor MSI-high or IHC abnormal - **result:** _____ ☐ Tumor not available for MSI or IHC testing
Ovarian cancer (Select applicable diagnosis/es): ☐ Left ovary ☐ Right ovary ☐ Left fallopian tube ☐ Right fallopian tube ☐ Peritoneum (cul-de-sac, mesentery, mesocolon, omentum, parietal, or pelvic)		☐	☐ Non-epithelial
☐ Prostate cancer		☐	**Gleason score:** ☐ Metastatic (includes distant metastasis and regional bed/nodes) ☐ NCCN high / very high risk
☐ 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+
☐ Hematologic cancer		☐	
☐ Pancreatic cancer		☐	
☐ Other cancer		☐	Type:
☐ Other cancer		☐	Type:

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**

☐ **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

If relative has not been tested, why?

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	Relative is deceased	Patient has no contact with relative	Relative declines testing
	☐	☐			☐	☐	☐	☐
	☐	☐			☐	☐	☐	☐
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	☐	☐			☐	☐	☐	☐

11. Breast cancer risk model information (Required for female patients only†)

Patient information:

Height ft: in: **Weight** (lbs):

Patient's age at time of first menstrual period:

Is patient currently: ☐ Pre-menopausal ☐ Peri-menopausal ☐ Post-menopausal **Age of post-menopausal onset:**

Has this patient had a live birth?: ☐ No ☐ Yes: **Patient's age at first child's birth:**

Has patient ever used hormone replacement therapy? ☐ No ☐ Yes

If yes, treatment type: ☐ Combined ☐ Estrogen only ☐ Progesterone only

If yes, is patient a: ☐ **Current user:** Started _____ years ago Intended use for _____ more years ☐ **Past user:** Stopped _____ years ago

Information about patient's female relatives:

Number of daughters:

Number of sisters:

Number of maternal aunts (mother's sisters):

Number of paternal aunts (father's sisters):

Other information:

Mammographic Density:

Has the patient had her breast density assessed? ☐ No ☐ Yes

If yes, complete one of the following for the most recent assessment:

☐ Volpara® Volumetric Density: _____ %

☐ VAS Percentage Density: _____ %

☐ BI-RADS® ATLAS Density (Select one of the following):

☐ a. Almost entirely fatty ☐ b. Scattered fibroglandular density ☐ c. Heterogeneously dense ☐ d. Extremely dense ☐ Unknown

NOTE: Risk associated with mammographic density is incorporated into RiskScore (v.2), and Tyrer-Cuzick (v.8) calculations provided on the clinical report.

Please indicate if the patient has had a breast biopsy showing one or more of the following results:

☐ N/A (No biopsy or none of the listed results) ☐ Hyperplasia (not atypia) ☐ Atypical hyperplasia ☐ LCIS ☐ Biopsy with unknown or pending results

*High-risk is defined as either 1) TNBC treated with either (a) adjuvant chemotherapy with axillary node-positive disease or an invasive primary tumor ≥2 cm on pathology analysis, or (b) neoadjuvant chemotherapy with residual invasive breast cancer in the breast or resected lymph nodes, or 2) hormone receptor positive disease treated with either (a) adjuvant chemotherapy with ≥4 positive pathologically confirmed lymph nodes, or (b) neoadjuvant chemotherapy which did not have a complete pathologic response, with a CPS+EG score of 3 or higher. †Female refers to the sex assigned at birth with regard to relatives and breast cancer risk model information.