Prolaris®

Prostate Cancer Prognostic Test

Myriad genetics

Myriad Genetic Laboratories, Inc.
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ProlarisCS@myriad.com

Biopsy Test Request Form (TRF)

Patient information

Patient name (last, first, m.i.)

Patient ID # (optional) | Birthdate (mm/dd/yyyy)

☑ Male ☐ Female

Street address

City | State | Zip

Daytime phone number | Alternate phone number

Email

Ordering provider

Name (last, first, degree) | NPI #

Myriad account #: (If new customer or account number is unknown, please complete the address info or call (800) 469-7423)

Address

City | State | Zip

Office contact | Phone | Fax

Email

Clinical information

Pre-biopsy total PSA: _____ ng/mL

Clinical stage (Based on DRE): ☐ T1a ☐ T1b ☐ T1c ☐ T2a ☐ T2b ☐ T2c ☐ T3a ☐ T3b ☐ T4

Biopsy cores: Total number of sites biopsied: _____ Total number of sites with positive core(s): _____

Date of biopsy: _____ (mm/dd/yyyy)

Prostate volume: _____cc **OR** prostate length: _____cm, width: _____cm, height: _____ cm

☐ **Patient has received pelvic radiation and/or androgen deprivation prior to their biopsy**

Highest Gleason score on current biopsy:

Primary grade + *Secondary grade* = *Gleason score*

_____ + _____ = _____

For Medicare patients only:

At the time of biopsy: ☐ Hospital inpatient (>24 hour stay) Discharge date (mm/dd/yyyy): _____ ☐ Hospital outpatient ☐ Non-hospital patient

Ancestry

Select all that apply: ☐ Ashkenazi Jewish ☐ Asian ☐ Black/African ☐ Hispanic/Latino ☐ Middle Eastern ☐ Native American ☐ Pacific Islander ☐ White/Non-Hispanic

Test offering

Prolaris Biopsy Test

Specimen information

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

Location of specimen | Phone | Fax | Contact name

☐ I have a specimen to send Myriad Genetic Laboratories. (Follow mailing instructions in the test kit.) **Specify:** ☐ Blocks and/or ☐ Slides

Hereditary risk assessment

Does patient have a close blood relative with breast cancer, ovarian cancer, pancreatic cancer, or prostate cancer? ☐ Yes ☐ No

Authorized signature

I hereby authorize testing and confirm that informed consent has been obtained, if required by state law. I confirm that the patient has localized prostate cancer and an estimated life expectancy of ≥ 10 years. I certify that I will discuss with the patient their test results and how their results helped inform treatment recommendations. 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. I confirm that I have on file the patient's assignment of benefits authorizing insurance benefits to be paid to ancillary healthcare service providers, such as Myriad Genetics Laboratories, Inc. (MGL). I authorize MGL to release the information on this form, and other information provided by me, necessary to process a claim for this service.

Healthcare Provider's signature | Date (mm/dd/yyyy)

Billing/payment information

☐ **Option 1: 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)

☐ Please bill my credit card (all major credit cards accepted) in the amount of $ _____ Card# _____ Exp. date: _____ (mm/dd/yyyy)

Cardholder name (please print): _____ Cardholder signature: _____

☐ Personal check, cashiers check, or money order enclosed, payable to Myriad Genetic Laboratories, Inc.

☐ **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 #: _____

Prolaris® Biopsy Test Request

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.

*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.