MYRIAD GENETIC LABORATORIES, INC.
320 Wakara Way • Salt Lake City, Utah 84108
Phone: (800) 231-4447
Fax: (801) 582-0072
Email: myPlan@Myriad.com

MYRIAD myPlan® Lung Cancer

Test Request Form

Clinical Experience Program (CEP)

TEST IS ONLY VALIDATED FOR STAGE I OR II NON-SMALL CELL LUNG ADENOCARCINOMA WITHOUT PRE-OPERATIVE RADIATION THERAPY AND/OR CHEMOTHERAPY

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, INITIAL)

PT ID (Optional) ☐ FEMALE ☐ MALE BIRTH DATE (MM/DD/YYYY)

STREET ADDRESS

CITY STATE ZIP

DAYTIME PHONE NUMBER ALTERNATE PHONE NUMBER

ORDERING PHYSICIAN

NAME (LAST, FIRST, DEGREE) NPI #

MD EMAIL MYRIAD ACCOUNT #:

STREET ADDRESS

CITY STATE ZIP

OFFICE CONTACT PHONE FAX

OFFICE CONTACT EMAIL

CLINICAL INFORMATION

Non-Small Cell Lung Adenocarcinoma? ☐ Yes ☐ No

Date of Resection: _____

☐ Patient has received neoadjuvant radiation and/or chemotherapy

Tumor Size: _____

TNM AND STAGE CLASSIFICATION GROUPING

TNM	T1a N0 M0	T1a N1 M0	T1b N0 M0	T1b N1 M0	T2a N0 M0	T2a N1 M0	T2b N0 M0	T2b N1 M0	T3 N0 M0
AJCC Stage 7th Edition	Stage IA	Stage IIA	Stage IA	Stage IIA	Stage IB	Stage IIA	Stage IIA	Stage IIB	Stage IIB
Check the Box that Applies	☐	☐	☐	☐	☐	☐	☐	☐	☐

Source: IASLC Staging Handbook in Thoracic Oncology. 7th ed. Orange Park, FL: 2009:41-100

INTENDED TREATMENT RECOMMENDATION: using the clinic-pathological information in the patient's chart please select the **INTENDED** modality of treatment

PLEASE COMPLETE ONLY ONE COLUMN AS DESCRIBED BELOW

NON-INTERVENTIONAL TREATMENTS

Chest Surveillance Alone:

Select Mode of Observation AND Interval for Mode of Observation

Select Mode of Observation	Interval for Mode of Observation
☐ X-ray	☐ Every 3 months
☐ CT	☐ Every 6 months
☐ CT-PET	☐ Every 12 months
☐ Other	☐ Other

Referral to Medical Oncologist: ☐ Yes ☐ No

Referral to Radiation Oncologist: ☐ Yes ☐ No

☐ Other: _____

INTERVENTIONAL TREATMENTS

Adjuvant Chemotherapy Alone: ☐ Yes ☐ No

Name of Chemotherapies: _____

Number of Cycles: _____

Adjuvant Radiation Therapy Alone: ☐ Yes ☐ No

Adjuvant Chemo/Radio Therapy: ☐ Yes ☐ No

☐ Other: _____

For Medicare Patients Only:

At the Time of Resection: Discharge Date: _____

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

MRP #: 368