



Hereditary Cancer Test Request Form

page 1 of 2

- Please submit both pages of this form
- Make sure information is complete and legible

NOTE: Affix Patient Identifier Label to Specimen Tube

FOR LAB USE

SPECIMEN COLLECTION DATE (REQUIRED)

(MM/DD/YYYY)

At the time of specimen collection: Hospital Inpatient (>24 hour stay) Discharge date: / / (MM/DD/YYYY) Hospital Outpatient Non-Hospital Patient

1. Patient Information (Complete information required)

Name (last)	Name (first)	(m.i.)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	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.

Myriad myRisk® Hereditary Cancer Panel Testing	Single-Syndrome Testing	Additional Tests*
HEREDITARY BREAST AND OVARIAN CANCER SYNDROME CRITERIA: <input type="checkbox"/> Integrated BRACAnalysis® with Myriad myRisk® Hereditary Cancer Update Test FOR PATIENTS OF ASHKENAZI JEWISH ANCESTRY: <input type="checkbox"/> Multisite 3 BRACAnalysis® <input type="checkbox"/> REFLEX to Integrated BRACAnalysis® with Myriad myRisk® Hereditary Cancer Update Test if the Multisite 3 is negative LYNCH SYNDROME OR MYH-ASSOCIATED POLYPOSI (MAP) CRITERIA: <input type="checkbox"/> COLARIS®PLUS with Myriad myRisk® Hereditary Cancer Update Test FAMILIAL POLYPOSI SYNDROME CRITERIA: <input type="checkbox"/> COLARIS AP®PLUS with Myriad myRisk® Hereditary Cancer Update Test FOR PATIENTS PREVIOUSLY TESTED AT MYRIAD: <input type="checkbox"/> Myriad myRisk® Update Test (Available to patients previously tested negative with BRACAnalysis®, COLARIS®, and/or COLARIS AP®, BART 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): <input type="checkbox"/> riskScore® is not appropriate for this patient <input type="checkbox"/> Tyrer-Cuzick and riskScore® are not appropriate for this patient	HEREDITARY BREAST AND OVARIAN CANCER SYNDROME CRITERIA: <input type="checkbox"/> Integrated BRACAnalysis® FOR PATIENTS OF ASHKENAZI JEWISH ANCESTRY: <input type="checkbox"/> Multisite 3 BRACAnalysis® <input type="checkbox"/> REFLEX to Integrated BRACAnalysis® if the Multisite 3 is negative LYNCH SYNDROME OR MYH-ASSOCIATED POLYPOSI (MAP) CRITERIA: <input type="checkbox"/> COLARIS®PLUS FAMILIAL POLYPOSI SYNDROME CRITERIA: <input type="checkbox"/> COLARIS AP®PLUS	<input type="checkbox"/> Single Site Testing: Specify Gene: _____ _____ 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. <input type="checkbox"/> 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. The person listed as the Ordering Physician is authorized by law to order the test(s) requested herein.

SIGN HERE: Medical Professional (required to process form)

X

Date: / / (MM/DD/YYYY)

(Signature date is the specimen collection date if a different date is not provided above)

6. Billing/Payment Information

OPTION 1: BILL INSURANCE (Please attach copy of authorization/referral)

Name of Policy Holder: _____ DOB: / / (MM/DD/YYYY)

Insurance ID#: _____ Patient Relation to Policy Holder: Self Spouse Child Other Authorization/Referral: _____

SIGN HERE: Patient/Responsible Party I AGREE TO THE BILLING TERMS ON REVERSE

X

DATE: / / (MM/DD/YYYY)

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: 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 #: _____

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



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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. 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.

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

TEST DESCRIPTIONS (For a full list of tests offered, visit www.myriadpro.com)

Integrated BRACAnalysis®: Analysis of <i>BRCA1</i> and <i>BRCA2</i> for susceptibility to Hereditary Breast and Ovarian Cancer syndrome.
Integrated BRACAnalysis® with Myriad myRisk® Hereditary Cancer Update Test: Analysis of <i>BRCA1</i> and <i>BRCA2</i> for susceptibility to Hereditary Breast and Ovarian Cancer syndrome with additional genes associated with hereditary cancer risk (see table below). May also include riskScore® breast cancer analysis. See below details for inclusion criteria.
Multisite 3 BRACAnalysis®: Three-mutation <i>BRCA1</i> and <i>BRCA2</i> analysis for individuals of Ashkenazi Jewish ancestry: <i>BRCA1</i> c.68_69del (p.Glu23Valfs*17) (aka <i>BRCA1</i> 185delAG, 187delAG); <i>BRCA1</i> c.5266dupC (p.Gln1756Profs*74) (aka <i>BRCA1</i> 5382insC, 5385insC); <i>BRCA2</i> c.5946del (p.Ser1982Argfs*22) (aka <i>BRCA2</i> 6174delT).
COLARIS®PLUS: Analysis of <i>MLH1</i> , <i>MSH2</i> , <i>MSH6</i> , <i>PMS2</i> , <i>MUTYH</i> , and <i>EPCAM</i> for susceptibility to Lynch syndrome (HNPCC) and <i>MYH</i> -Associated Polyposis (MAP).
COLARIS®PLUS with Myriad myRisk® Hereditary Cancer Update Test: Analysis of <i>MLH1</i> , <i>MSH2</i> , <i>MSH6</i> , <i>PMS2</i> , <i>MUTYH</i> , and <i>EPCAM</i> for susceptibility to Lynch syndrome (HNPCC) and <i>MYH</i> -Associated Polyposis (MAP) with additional genes associated with hereditary cancer risk (see table below). May also include riskScore® breast cancer analysis. See below details for inclusion criteria.
COLARIS AP®PLUS: Analysis of <i>APC</i> for susceptibility to FAP/AFAP.
COLARIS AP®PLUS with Myriad myRisk® Hereditary Cancer Update Test: Analysis of <i>APC</i> for susceptibility to FAP/AFAP with additional genes associated with hereditary cancer risk. May also include riskScore® breast cancer analysis. See below details for inclusion criteria.
Single Site Testing: Analysis of single, familial mutation.
Myriad myRisk® Update Test: Analysis of 29 hereditary cancer genes for patients who previously tested negative for <i>BRACAnalysis</i> ®, <i>COLARIS</i> ®, and/or <i>COLARIS AP</i> ®. <i>BART</i> and/or <i>PMS2</i> testing will be included in the test order unless previously performed or restricted by payer criteria. May also include riskScore® breast cancer analysis. See below details for inclusion criteria.

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®. Please visit www.myriadpro.com/payeroptout to determine if your patient's payer does not reimburse for hereditary cancer genetic testing with SNP analysis.

Genes & Associated Cancers*	Br	Ov	Co	En	Me	Pa	Ga	Pr
<i>BRCA1</i>	•	•				•		•
<i>BRCA2</i>	•	•				•		•
<i>MLH1</i> , <i>MSH2</i> , <i>MSH6</i> , <i>PMS2</i> , <i>EPCAM</i> **		•	•	•		•	•	•
<i>APC</i>			•			•	•	
<i>MUTYH</i>			•					
<i>CDK4</i> , <i>CDKN2A</i> (p16INK4a, p14ARF)					•	•		
<i>TP53</i>	•	•	•	•	•	•	•	•
<i>PTEN</i>	•		•	•	•			
<i>STK11</i>	•	•	•	•			•	•
<i>CDH1</i>	•	•	•					•
<i>BMPRIA</i> , <i>SMAD4</i>			•			•	•	
<i>PALB2</i> , <i>ATM</i>	•					•		
<i>CHEK2</i>	•		•					
<i>NBN</i>	•							•
<i>BARD1</i>	•							
<i>BRIP1</i>		•						
<i>RAD51C</i> , <i>RAD51D</i>		•						
<i>POLD1</i> , <i>POLE</i>			•					
<i>GREM1</i>			•					
<i>HOXB13</i>								•

Br: Breast / Ov: Ovarian / Co: Colorectal / En: Endometrial / Me: Melanoma / Pa: Pancreatic / Ga: Gastric / Pr: Prostate

*Additional risks may be associated with each gene/syndrome. **Large rearrangement only.

riskScore® is calculated for women under age 85, of solely White/Non-Hispanic and/or Ashkenazi Jewish ancestry, without a personal history of breast cancer, LCIS, hyperplasia, atypical hyperplasia, or a breast biopsy with unknown results. riskScore® is not calculated if a woman or blood relative is known to carry a mutation in a breast cancer risk gene. 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.

- The genes associated with Myriad myRisk® Hereditary Cancer Panel are subject to change. To ensure you have a current version of the TRF and the genes included with the Myriad myRisk panel please visit www.myriadpro.com/documents-and-forms/test-request-forms and www.myriadpro.com/myrisk/why-myriad-myrisk/gene-selection.
- For additional information visit MySupport360.com and MyriadPro.com

Turnaround Time:

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

Myriad 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, gender and cancer family history

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.

7. Patient Information (Make sure information is the same as entered on page 1)

Name (last)	(first)	(mi.)	Birthdate (MM/DD/YYYY)
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8. Ancestry (riskScore® is currently only validated and provided for patients of solely White/Non-Hispanic and/or Ashkenazi Jewish ancestry)

Select all that apply:

<input type="checkbox"/> Ashkenazi Jewish	<input type="checkbox"/> Black / African	<input type="checkbox"/> Middle Eastern	<input type="checkbox"/> Pacific Islander
<input type="checkbox"/> Asian	<input type="checkbox"/> Hispanic / Latino	<input type="checkbox"/> Native American	<input type="checkbox"/> White / Non-Hispanic

9. Patient Personal History of Cancer & Other Clinical Information (Select all that apply)

No personal history of cancer

Patient has been diagnosed with:	Age at Diagnosis	Patient is Currently Being Treated	Pathology / Other Info
<input type="checkbox"/> Breast Cancer <input type="checkbox"/> Left <input type="checkbox"/> Right		<input type="checkbox"/>	<input type="checkbox"/> Ductal Invasive <input type="checkbox"/> Lobular Invasive <input type="checkbox"/> DCIS <input type="checkbox"/> Bilateral <input type="checkbox"/> Triple-Negative (ER-, PR-, HER2-) HER2 Status: <input type="checkbox"/> + <input type="checkbox"/> - <input type="checkbox"/> Metastatic: Previous Chemotherapy: <input type="checkbox"/> Yes <input type="checkbox"/> No If ER/PR+, previous Endocrine Therapy: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A or inappropriate
<input type="checkbox"/> Endometrial / Uterine Cancer		<input type="checkbox"/>	<input type="checkbox"/> Tumor MSI-High or IHC Abnormal - Result: _____ <input type="checkbox"/> Tumor not available for MSI or IHC testing
<input type="checkbox"/> Ovarian Cancer		<input type="checkbox"/>	<input type="checkbox"/> Non-epithelial
<input type="checkbox"/> Prostate Cancer		<input type="checkbox"/>	Gleason Score: _____ <input type="checkbox"/> Metastatic
<input type="checkbox"/> Colon / Rectal Cancer		<input type="checkbox"/>	Type: <input type="checkbox"/> Mucinous <input type="checkbox"/> Signet Ring <input type="checkbox"/> Medullary Growth Pattern <input type="checkbox"/> Tumor Infiltrating Lymphocytes <input type="checkbox"/> Crohn's-like Lymphocytic Reaction <input type="checkbox"/> Patient's tumor is MSI-High or IHC Abnormal - Result: _____ <input type="checkbox"/> Tumor not available for MSI or IHC testing
<input type="checkbox"/> Colon / Rectal Adenomas		<input type="checkbox"/>	Cumulative Adenomatous Polyp #: <input type="checkbox"/> 1 <input type="checkbox"/> 2-5 <input type="checkbox"/> 6-9 <input type="checkbox"/> 10-19 <input type="checkbox"/> 20-99 <input type="checkbox"/> 100+
<input type="checkbox"/> Hematologic Cancer		<input type="checkbox"/>	
<input type="checkbox"/> Other Cancer		<input type="checkbox"/>	Type _____
<input type="checkbox"/> Other Cancer		<input type="checkbox"/>	Type _____

Check if applicable to patient: _____ % on one of the Lynch Syndrome Risk Models (PREMM₅, MMRpro, or MMRpredict)

Bone Marrow Transplant Recipient Type: Autologous Allogeneic (If allogeneic please call 800-469-7423 x3850)

Blood Transfusion Recipient Type: Whole blood Packed red blood cells 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

Relationship to Patient	Maternal (mother's side)	Paternal (father's side)	Cancer Site or Polyp Type (add # for colon/rectal adenomas)	Age at Each Diagnosis
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		

11. Breast Cancer Risk Model Information

Only complete for female patients NEVER diagnosed with breast cancer.

Patient information: Height - ft: _____ in: _____ Weight (lbs): _____ Age at time of first menstrual period: _____ Is patient: <input type="checkbox"/> Pre-menopausal <input type="checkbox"/> Peri-menopausal <input type="checkbox"/> Post-menopausal: Age of onset: _____ Has this patient had a live birth?: <input type="checkbox"/> No <input type="checkbox"/> Yes: patient's age at first child's birth: _____ Has patient ever used Hormone Replacement Therapy? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Treatment Type: <input type="checkbox"/> Combined <input type="checkbox"/> Estrogen only <input type="checkbox"/> Progesterone only If Yes, is patient a: <input type="checkbox"/> Current User: Started _____ years ago Intended use for _____ more years <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, complete one of the following for the most recent assessment: <input type="checkbox"/> Volpara® Volumetric Density: _____, _____ % <input type="checkbox"/> VAS Percentage Density: _____, _____ % <input type="checkbox"/> BI-RADS® ATLAS Density (Select one of the following): <input type="checkbox"/> Almost entirely fatty <input type="checkbox"/> Heterogeneously dense <input type="checkbox"/> Scattered fibroglandular density <input type="checkbox"/> Extremely dense <input type="checkbox"/> Unknown <small>NOTE: Risk associated with mammographic density is not incorporated into riskScore (v.1), nor Tyrer-Cuzick (v.7) calculations provided on the clinical report.</small>
Please indicate if the patient has had a breast biopsy showing one or more of the following results: <input type="checkbox"/> N/A (No biopsy or none of the listed results) <input type="checkbox"/> Hyperplasia <input type="checkbox"/> Atypical Hyperplasia <input type="checkbox"/> LCIS <input type="checkbox"/> Biopsy with unknown or pending results		

