Hereditary Cancer Test Request Form

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

FOR LAB USE

SPECIMEN COLLECTION DATE (REQUIRED)

NOTE: Affix Patient Identifier Label to Specimen Tube

1. Patient Information (Complete information required)

Name (last, first, middle initial)	Gender ☐ Male ☐ Female	Birthdate (MM/DD/YYYY)	Patient ID #	Email

Address	City	State	Zip	Cell phone	Daytime phone

2. Ordering Physician Information (Only name and HCP Account # required unless you're a new customer or HCP # is unknown)

Name (last, first)	Myriad HCP Account #	Degree	NPI #

Address	City	State	Zip

Office Contact Name	Phone	Fax	Email

3. Additional Results Recipient (Additional clinician will receive cancellation notices and patient's copy of the test results)

Name (last, 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.

- ☐ **Integrated BRAC*Analysis*® with Myriad myRisk® Hereditary Cancer Update Test** (HBOC criteria)
- ☐ **Multisite 3 BRAC*Analysis***
  - ☐ REFLEX to Integrated BRAC*Analysis* with Myriad myRisk Hereditary Cancer Update Test if the Multisite 3 is negative
  - ☐ Check here if a family member has tested positive for one of the Multisite 3 mutations (see reverse)
- ☐ **COLARIS®PLUS with Myriad myRisk Hereditary Cancer Update Test** (Lynch criteria)
- ☐ **COLARIS AP®PLUS with Myriad myRisk Hereditary Cancer Update Test** (Familial Polyposis syndrome criteria)
- ☐ **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.
- ☐ **Myriad myRisk Update Test** (available to patients previously tested negative with BRAC*Analysis*®, 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.)
- ☐ **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: _____

(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: _____ 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: _____

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 relavant 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.

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

Integrated BRACAnalysis® with Myriad myRisk® Hereditary Cancer Update Test	Analysis of *BRCA1* and *BRCA2* for susceptibility to Hereditary Breast and Ovarian Cancer syndrome with additional genes associated with hereditary cancer risk (see table below)
Multisite 3 BRACAnalysis®	Three-mutation *BRCA1* and *BRCA2* analysis for individuals of Ashkenazi Jewish ancestry: c.5946del (p.Ser1982Argfs*22) (aka 6174delT), c.68_69del (p.Glu23Valfs*17) (aka 185delAG, 187delAG), c.5266dupC (p.Gln1756Profs*74) (aka 5385insC, 5382insC)
COLARIS®PLUS with Myriad myRisk® Hereditary Cancer Update Test	Analysis of *MLH1, MSH2, MSH6, PMS2, MUTYH,* and *EPCAM* for susceptibility to Lynch syndrome, with additional genes associated with hereditary cancer risk (see table below)
COLARIS AP®PLUS with Myriad myRisk® Hereditary Cancer Update Test	Analysis of *APC* for susceptibility to FAP/AFAP with additional genes associated with hereditary cancer risk
Single Site Testing	Analysis of single, familial mutation
Myriad myRisk® Update Test	Analysis of 28 hereditary cancer genes for patients who previously tested negative for BRAC*Analysis*®, 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.

Genes & Associated Cancers*	Br	Ov	Co	En	Me	Pa	Ga	Pr
BRCA1	●	●				●		●
BRCA2	●	●			●	●		●
*MLH1, MSH2, MSH6, PMS2, EPCAM***		●	●	●		●	●	
APC			●			●	●	
MUTYH			●					
CDK4, CDKN2A (p16INK4a, p14ARF)					●	●		
TP53	●	●	●	●	●	●	●	●
PTEN	●		●	●	●			
STK11	●	●	●	●		●	●	
CDH1	●		●				●	
BMPR1A, SMAD4			●			●	●	
PALB2, ATM	●					●		
CHEK2	●		●					●
NBN	●							●
BARD1	●							
BRIP1		●						
RAD51C, RAD51D		●						
POLD1, POLE			●					
GREM1			●					

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.

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
- myRisk Management Tool
  - Guideline based (NCCN, CAPS, Amsterdam, and others) cancer management for both positive and negative results

Completing the Test Request Form:

- Please include:
  - Age and cancer diagnosis
  - Gender and relationship

The myRisk Management Tool may not be reported without an accurate and specific personal and family history included on the Patient Cancer Family History Form

- 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

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

Name (last, first, middle initial)	Birthdate (MM/DD/YYYY)

8. Ancestry

Select all that apply:

☐ White / Non-Hispanic ☐ Hispanic / Latino ☐ Black / African ☐ Ashkenazi Jewish ☐ Asian ☐ Native American ☐ Pacific Islander ☐ Middle Eastern ☐ Other _____

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
☐ **Breast Cancer** ☐ **Left** ☐ **Right**		☐	☐ Ductal Invasive ☐ Lobular Invasive ☐ DCIS ☐ Bilateral ☐ Premenopausal ☐ Triple Negative (ER-, PR-, HER2-)
☐ **Endometrial / Uterine Cancer**		☐	☐ Tumor MSI-High or IHC Abnormal - Result _____
☐ **Ovarian Cancer**		☐	☐ Non-epithelial
☐ **Prostate Cancer**		☐	Gleason Score _____
☐ **Colon / 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 _____
☐ **Colon / Rectal Adenomas**		☐	Cumulative Adenomatous Polyp #: ☐ 1 ☐ 2-5 ☐ 6-9 ☐ 10-19 ☐ 20-99 ☐ 100+
☐ **Hematologic Cancer**		☐	
☐ **Other Cancer**		☐	Type _____
☐ **Other Cancer**		☐	Type _____

Check if applicable to patient:	_____% on one of the Lynch Syndrome Risk Models (PREMM$_{1,2,6,}$ MMRpro, or MMRpredict)
	☐ Bone Marrow Transplant Recipient

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
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		

11. Breast Cancer Risk Model Information

Only complete for female patients NEVER affected with breast cancer

PATIENT INFORMATION:

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

Age at time of first menstrual period: _____

Is patient: ☐ Pre-menopausal ☐ Peri-menopausal ☐ Post-menopausal: Age of onset _____

Has this patient had a live birth?: ☐ No ☐ Yes: **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 _____ yrs ago Intended use for _____ more yrs ☐ **Past User:** Stopped _____ years ago

If patient has had breast biopsy did it show:
☐ No Benign Disease ☐ Hyperplasia ☐ Atypical Hyperplasia ☐ LCIS ☐ Biopsy Result Unknown ☐ N/A

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): _____