BRACAnalysis CDx®

Germline Companion Diagnostic Test

To avoid delays please complete entire form

Specimen collection date (required)

(mm/dd/yyyy)

Myriad genetics

Myriad Genetic Laboratories, Inc.
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(800) 469-7423 • (801) 584-1100
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Test Request Form

1. 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

2. 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

3. 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 (this enables us to contact the patient if there is an issue with their order or sample) ☐I don't have the patient's email	Cell phone	Daytime phone

Address	City	State	Zip

4. Ancestry & clinical history (Select all that apply)

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

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
Ovarian cancer (Select applicable diagnosis/es): ☐**Left ovary** ☐**Right ovary** ☐**Left fallopian tube** ☐**Right fallopian tube** ☐**Peritoneum** (cul-de-sac, mesentery, mesocolon, omentum, parietal, pelvic)		☐	☐Non-epithelial		
☐**Pancreatic cancer**		☐			
☐**Prostate cancer**		☐	**Gleason score:**	☐Metastatic (includes distant metastasis and regional bed/nodes)	☐NCCN high/very high risk
☐**Other cancer**		☐	**Type:**		

Check if applicable to patient:

☐**Bone marrow transplant recipient** **Type:** ☐Autologous ☐Allogeneic (If allogeneic please call 800-469-7423 x3850)

☐**Diagnosis of a hematologic cancer** **Type:**

☐**ICD-10 code(s) / Dx:**

☐**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

Family history of cancer Relationship to patient	Maternal (mother's side)	Paternal (father's side)	Cancer site or polyp type (if colon/rectal adenomas, include total number)	Age at each diagnosis
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		

5. Test requested

☑ **BRACAnalysis CDx®** - *BRCA1* and *BRCA2* gene sequence and large rearrangement analysis to identify the presence of *BRCA1/2* mutation(s). Results of the test are used as an aid in identifying breast cancer patients who are or may become eligible for treatment with LYNPARZA® (olaparib) or TALZENNA® (talazoparib). Further, results of the test are used as an aid in identifying ovarian cancer patients who are or may become eligible for treatment with LYNPARZA® (olaparib) or ZEJULA® (niraparib). In addition, results of the test are also used for pancreatic and prostate cancer patients who are or may become eligible for treatment with LYNPARZA® (olaparib). For more detailed information, including a complete list of Contraindications, Limitations, Warnings and Precautions of the assay, please see page 2 of the BRACAnalysis CDx® Technical Information at https://s3.amazonaws.com/myriad-web/BRACAnalysisCDxTS.pdf.

6. 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)

7. Billing/payment information

☐ **Option 1: Bill insurance** *(Please attach copy of authorization/referral)*

Name of policy holder: _____ Name of insurance: _____

DOB: _____ (mm/dd/yyyy) Insurance ID#: _____

Sign here: Patient/responsible party I agree to the billing terms on reverse. X _____ Authorization/referral: _____

Patient relation to policy holder: ☐Self ☐Spouse ☐Child ☐Other

I understand that Myriad Genetics 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 .

Reminder: Include a copy of both sides of your insurance card(s).

If you submit more than one card, indicate which is primary.

☐ **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 #:

*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 chmotherapy 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.

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.