

- Make sure information is complete and legible
- Supply all relevant documents insurance cards, clinical notes, and pathology reports

For lab use

Blood sample collection date (required)

____ / ____ / ____
(MM/DD/YYYY)

For lab use

1. Patient information (Complete information required.) Please check here if any patient information has changed since the patient's initial test.

Legal name (last)	Legal name (first)	(m.i.)	Sex at birth <input type="checkbox"/> M <input type="checkbox"/> 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) <input type="checkbox"/> Don't have patient's email		Phone number		Alternate phone number (optional)	
Address			City	State	Zip

Required patient information - Myriad Genetics will use this information to contact the patient via e-mail, SMS and/or phone regarding payment, test processing status and online results access, or as otherwise outlined in the Informed Consent document. By submitting this requisition, I confirm that I have obtained the patient's express authorization to be contacted by Myriad through any of these means.

2. Ordering provider information (Only name and HCP Account # required unless you're a new provider 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 - an additional clinician can be listed to receive a copy of the test results. Pathologist will automatically receive results.)

Name (last)	Name (first)	Myriad HCP account #	Degree	NPI #
Address		City	State	Zip
Office contact name	Phone	Fax	Email	

4. Clinical information (Clinical information is required for first time orders. For follow-up testing, only complete if clinical information has changed.)

Diagnosis	Stage*	Clinical information		Treatment timepoint (select one)
Cancer type (select one) <input type="checkbox"/> Breast <input type="checkbox"/> Colorectal <input type="checkbox"/> Renal Subtype (if applicable) _____	<input type="checkbox"/> Stage II <input type="checkbox"/> Stage III <input type="checkbox"/> Stage IV	Active disease? <input type="checkbox"/> Yes <input type="checkbox"/> No History of metastatic disease for this diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of diagnosis: ____ / ____ / ____ (Planned) surgery date: ____ / ____ / ____	<input type="checkbox"/> Neoadjuvant <input type="checkbox"/> Adjuvant <input type="checkbox"/> Surveillance <input type="checkbox"/> Metastatic

*We cannot accept stage 0 or stage I samples at this time.

5. Testing requested

Precise MRD™ test selection	
<input type="checkbox"/> Initial test order (Precise MRD Baseline) <input type="checkbox"/> Follow-up test order (Precise MRD Monitoring)	Select only <i>one</i> testing cadence option: Indication-based MRD & monitoring schedule OR Custom monitoring schedule* <input type="checkbox"/> Neoadjuvant therapy-based schedule <input type="checkbox"/> Adjuvant therapy-based schedule <input type="checkbox"/> Surveillance schedule* <input type="checkbox"/> Single draw NOTE: Monitoring frequency may be adjusted by the ordering provider by calling (877) 283-6709.

*Order valid for 12 months

6. Authorized signature

I hereby attest that I am licensed to order and authorize the selected test(s) for the referenced patient, have obtained their informed consent, and the results will be used in the patient's medical management and treatment decisions. I confirm that I have on file and can provide the patient's assignment of benefits authorizing benefits to be paid to Myriad and that Myriad may pursue all necessary appeals of any denials of payment. I agree to provide additional information or documentation to support medical necessity upon request, and authorize the disease panel, patient results, and report to be amended in accordance with payer medical policy. I authorize Myriad Genetics, Inc. to request tissue specimen(s) for this patient.

Sign here: Medical professional
(Required to process form)

Date: _____ (mm/dd/yyyy)
(Signature date is the specimen collection date unless a different date is provided)



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

Legal name (last)	Legal name (first)	(m.i.)	Birthdate (mm/dd/yyyy)
-------------------	--------------------	--------	------------------------

8. Specimen retrieval information

Blood specimen <i>Required for all Precise MRD tests</i>	Tumor specimen <i>Required for all initial Precise MRD tests</i>	A pathology report <u>must</u> be submitted with this form.
<input type="checkbox"/> Myriad manages collection <input type="checkbox"/> Clinic manages first draw, Myriad manages subsequent blood draws <input type="checkbox"/> Clinic manages collection	<input type="checkbox"/> Myriad manages shipment (default) <input type="checkbox"/> Clinic will arrange shipment	Specimen identification number
	Pathology lab name	Phone
	Contact name	Fax
		Tissue type submitted
		Additional histopathology

Medicare patients only: Blood specimen collection was for: Non-hospital patient Hospital outpatient Hospital inpatient (>24 hour stay) Discharge date: _____(mm/dd/yyyy)

9. Billing/payment information

<input type="checkbox"/> Option 1: Bill insurance: (Please attach copy of authorization/referral)		Reminder: Include a copy of both sides of patient's insurance card(s). If you submit more than one card, indicate which is primary.
Name of policy holder: _____	Insurance ID#: _____	
DOB: _____ (mm/dd/yyyy)	Authorization/referral: _____	
Name of insurance: _____	Patient relation to policy holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
<input type="checkbox"/> Option 2: Uninsured		
<input type="checkbox"/> Option 3: Other billing (To establish an account, submit billing information with this form)		
<input type="checkbox"/> Bill our institutional account #: _____ or established research project code #: _____ or Authorization/voucher #: _____		

Certain scenarios may affect the results of this test

NOTE: Do not place an order using a blood sample for testing if the patient has had an **allogeneic bone marrow transplant**, an **allogeneic stem cell transplant**, a **hematologic malignancy** (i.e. leukemia, lymphoma), or is **currently pregnant**, as this may interfere with result interpretation. Treatment-naïve tumor samples are highly preferred. For patients who have had a whole blood transfusion, wait 28 days before collecting a sample. Please direct related questions to Myriad Medical Services: (800) 469-7423 ext. 3852.

Definitions

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.

