Myriad Hereditary Cancer Panel Tests

- 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:
- ☐ Breast Cancer Panel (104)
- ☐ Ovarian Cancer Panel (105)
- ☐ Breast and Ovarian Cancer Panel (101)
- ☐ Pancreatic Cancer Panel (111)
- ☐ HBOC and Lynch Syndrome Panel (112)
- ☐ Myriad myRisk® Hereditary Cancer Update Test

☐ **Multisite 3 BRAC*Analysis*®**
- ☐ Check here if a family member has tested positive for one of the three mutations (see reverse)

If Multisite 3 is negative, REFLEX to Integrated BRAC*Analysis*® with:
- ☐ Breast Cancer Panel (104R)
- ☐ Ovarian Cancer Panel (105R)
- ☐ Breast and Ovarian Cancer Panel (101R)
- ☐ Pancreatic Cancer Panel (111R)
- ☐ HBOC and Lynch Syndrome Panel (112R)
- ☐ Myriad myRisk® Hereditary Cancer Update Test

Colaris®PLUS with:
- ☐ Colorectal Cancer High-Risk Panel (107)
- ☐ Colorectal and Polyposis Panel (102)
- ☐ Myriad myRisk® Hereditary Cancer Update Test

Colaris *AP*®PLUS with:
- ☐ Colorectal High-Risk Panel (108)
- ☐ Colorectal and Polyposis Panel (103)
- ☐ Myriad myRisk® Hereditary Cancer Update Test

Single Gene COLARIS®: ☐ *MLH1* ☐ *MSH2 / EPCAM* ☐ *MSH6* ☐ *PMS2*

If Single-Gene COLARIS® is negative, REFLEX to Colaris®PLUS with:
- ☐ Colorectal Cancer High-Risk Panel (107R)
- ☐ Colorectal and Polyposis Panel (102R)
- ☐ Myriad myRisk® Hereditary Cancer Update Test

☐ **Single Site Testing** *(for family of known mutation carriers)*
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:** _____

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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Myriad Hereditary Cancer Panel Tests

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

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.

TEST OVERVIEW

Integrated BRAC*Analysis*® with Breast and Ovarian Cancer Panel (101)	Analysis of *BRCA1*, *BRCA2*, *ATM*, *CHEK2*, *PALB2*, *BARD1*, NBN, *TP53*, *CDH1*, *PTEN*, *STK11*, *BRIP1*, *RAD51C*, *RAD51D*, *MLH1*, *MSH2*, *MSH6*, *PMS2*, and *EPCAM***
Colaris®PLUS with Colorectal and Polyposis Panel (102)	Analysis of *APC*, *MUTYH*, *MLH1*, *MSH2*, *MSH6*, *PMS2*, *EPCAM***, *POLD1****, *POLE****, *GREM1***, *STK11*, *BMPR1A*, *CDH1*, *SMAD4*, *TP53*, *PTEN*, and *CHEK2* (For patients who meet Lynch syndrome criteria)
Colaris *AP*®PLUS with Colorectal and Polyposis Panel (103)	Analysis of *APC*, *MUTYH*, *MLH1*, *MSH2*, *MSH6*, *PMS2*, *EPCAM***, *POLD1****, *POLE****, *GREM1***, *STK11*, *BMPR1A*, *CDH1*, *SMAD4*, *TP53*, *PTEN*, and *CHEK2* (For patients who meet Polyposis criteria)
Integrated BRAC*Analysis*® with Breast Cancer Panel (104)	Analysis of *BRCA1*, *BRCA2*, *CDH1*, *PTEN*, *TP53*, *ATM*, *CHEK2*, and *PALB2*
Integrated BRAC*Analysis*® with Ovarian Cancer Panel (105)	Analysis of *BRCA1*, *BRCA2*, *PALB2*, *EPCAM***, *MLH1*, *MSH2 MSH6*, *PMS2*, *BRIP1*, *RAD51C*, and *RAD51D*
Colaris®PLUS with Colorectal Cancer High-Risk Panel (107)	Analysis of *EPCAM***, *MLH1*, *MSH2*, *MSH6*, *PMS2*, *APC*, and *MUTYH* (For patients who meet Lynch syndrome criteria)
Colaris *AP*®PLUS with Colorectal Cancer High-Risk Panel (108)	Analysis of *EPCAM***, *MLH1*, *MSH2*, *MSH6*, *PMS2*, *APC*, and *MUTYH* (For patients who meet Polyposis criteria)
Integrated BRAC*Analysis*® with Pancreatic Cancer Panel (111)	Analysis of *BRCA1*, *BRCA2*, *EPCAM***, *MLH1*, *MSH2*, *MSH6*, *PMS2*, *ATM*, *CDKN2A*, *PALB2*, *TP53*, *STK11*, and *APC*
Integrated BRAC*Analysis*® with HBOC & Lynch Syndrome Panel (112)	Analysis of *BRCA1*, *BRCA2*, *EPCAM***, *MLH1*, *MSH2*, *MSH6*, and *PMS2*
Multisite 3 BRAC*Analysis*®	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)
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.
Integrated BRAC*Analysis*® 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)
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

Panels & Associated Genes*	Breast and Ovarian Cancer Panel (101)	Colorectal and Polyposis Panel (102 & 10 3)†	Breast Cancer Panel (104)	Ovarian Cancer Panel (105)	Colorectal Cancer High-Risk Panel (107 & 108)^	Pancreatic Cancer Panel (111)	HBOC & Lynch Syndrome Panel (112)	Myriad myRisk® Update Test
BRCA1, BRCA2	●		●	●		●	●	●
ATM	●		●			●		●
CHEK2	●	●	●					●
PALB2	●		●	●		●		●
TP53	●	●	●			●		●
CDH1	●	●	●					●
PTEN	●	●	●					●
STK11	●	●				●		●
BRIP1	●			●				●
RAD51C	●			●				●
RAD51D	●			●				●
*MLH1, MSH2, MSH6, PMS2, EPCAM***	●	●		●	●	●	●	●
APC		●			●	●		●
MUTYH		●			●			●
CDKN2A (p16INK4a & p14ARF)						●		●
*GREM1***		●						●
*POLD1****		●						●
*POLE****		●						●
BMPR1A		●						●
SMAD4		●						●
BARD1, NBN	●							●

Turnaround Time:

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

Myriad Panel Reports include:

- Genetic Test Result
- Management Tool
  - for positive results, a management tool outlining the gene-associated risks and medical management considerations is provided

Completing the Test Request Form:

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

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

**Large rearrangement only.

***Exonuclease domain sequencing only.

† For patients who meet Lynch syndrome criteria order: Colorectal Cancer and Polyposis Panel (102).

† For patients who meet Polyposis syndrome criteria order: Colorectal and Polyposis Panel (103).

^ For patients who meet Lynch syndrome criteria order: Colorectal Cancer High-Risk Panel (107).

^ For patients who meet Polyposis syndrome criteria order: Colorectal Cancer High-Risk Panel (108).

- The genes associated with Myriad panel tests are subject to change. To ensure you have a current version of the TRF and the genes included with each panel please visit **www.myriadpro.com/documents-and-forms/test-request-forms** and **www.myriadpro.com/myrisk/why-myriad-myrisk/gene-selection or www.myriadpro.com/paneltests**.
- 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

For myRisk® Hereditary Cancer orders ONLY.
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): _____