myriad®

EndoPredict®

TEST REQUEST FORM

TO AVOID DELAYS PLEASE COMPLETE ENTIRE FORM

MYRIAD GENETIC LABORATORIES, INC.
320 Wakara Way • Salt Lake City, Utah 84108
Phone: (844) 887-3636 | Fax: (801) 583-8248
Email: EndoPredict@Myriad.com

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, INITIAL)

PATIENT ID # (OPTIONAL) ☐ FEMALE ☐ MALE BIRTH DATE (MM/DD/YYYY)

STREET ADDRESS

CITY STATE ZIP

DAYTIME PHONE NUMBER

E-MAIL

ORDERING PHYSICIAN (Only fill out first line unless new customer or HCP# is unknown)

NAME (LAST, FIRST, DEGREE) MYRIAD HCP ACCOUNT NO: (If known)

NPI # E-MAIL ADDRESS

ADDRESS

CITY STATE ZIP

OFFICE CONTACT PHONE FAX

EMAIL

CLINICAL INFORMATION

☐ Invasive Breast Cancer Age at Dx: _____ Procedure (surgery or biopsy) Date: _____ (MM/DD/YYYY)

Tumor Stage: ☐ pT1a (> 0.1 cm but ≤ 0.5 cm) ☐ pT1b (> 0.5 cm but ≤ 1 cm) ☐ pT1c (> 1 cm but ≤ 2 cm) ☐ pT2 (> 2 cm but ≤ 5 cm) ☐ pT3 (> 5 cm) ☐ pTx

Lymph Node Status: ☐ pN0 (zero positive nodes) ☐ pN1 (1 - 3 positive nodes; excluding pNmi) ☐ pN1mi (> 0.2 mm and/or >200 cells but < 2mm) ☐ pNx

FOR MEDICARE PATIENTS ONLY:

At the time of procedure: ☐ Hospital Inpatient (>24 hour stay) Discharge Date: _____ (MM/DD/YYYY) ☐ Hospital Outpatient ☐ Non-Hospital Patient

PATIENT TREATMENT PLAN

☐ Patient is CURRENTLY receiving adjuvant hormonal therapy
☐ Patient has received chemotherapy for THIS DIAGNOSIS
☐ Patient is a candidate for adjuvant chemotherapy
☐ Patient is a candidate for extended endocrine therapy

TEST REQUESTED

EndoPredict - a next-generation breast cancer recurrence test that integrates tumor biology and pathology to accurately predict individualized early (0-10 year) and late (5-15 year) distant recurrence after 5 years of endocrine therapy, and an absolute chemotherapy benefit. The test provides a 12-Gene Molecular Score. This is combined with tumor size and nodal status to calculate an EPclin Risk Score. The risks of early and late distant recurrence with 5 years of adjuvant endocrine therapy alone, and the estimated absolute benefit of chemotherapy are determined from the EPclin Risk Score. Recurrence risk and chemotherapy benefit estimates are based on the analysis of cohorts of women with ER+/HER2– invasive female breast cancer who have NOT been treated prior to resection with systemic neo-adjuvant therapy (e.g., chemotherapy, radiation, or endocrine therapy) and who do not have a current or prior diagnosis of an additional cancer. Risks may differ for individuals who do not meet the aforementioned clinical characteristics. This test is not appropriate for patients who have already experienced a distant recurrence.

SPECIMEN INFORMATION

Sample Fixative (check one): ☐ 10% neutral buffered formalin ☐ Other (describe): _____

Tissue Type Submitted: ☐ Breast Resection (preferred) ☐ Breast Biopsy

Date Specimen Retrieved from Archive: _____ (MM/DD/YYYY)

SPECIMEN RETRIEVAL

☐ I want Myriad Genetic Laboratories, Inc. to request the specimen. (COMPLETE the information below.)

LOCATION OF SPECIMEN PHONE FAX CONTACT NAME

AUTHORIZED SIGNATURE

I hereby authorize testing and confirm that informed consent has been obtained, if required by state law. I hereby attest that the person listed in the Ordering Physician space above is authorized by law in the relevant jurisdiction to order the test(s) requested herein. By signing this form I attest that the patient meets the inclusion criteria stated in the Test Requested section above. Individual and treating physician have had a discussion prior to testing regarding the potential results of the test and determined to use the results to guide therapy.

HEALTHCARE PROVIDER'S SIGNATURE DATE (MM/DD/YYYY)

BILLING/PAYMENT INFORMATION

☐ **OPTION 1: PLEASE BILL INSURANCE** (For Medicare patients: only available if test order date is more than 2 weeks after discharge date)

Include enlarged copies of both sides of insurance card(s). If two cards are submitted, indicate which is primary.

☐ **OPTION 2: PATIENT PAYMENT** (Please call Customer Service for questions regarding test prices)

☐ **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 #: _____