MYRIAD®
MYRIAD GENETIC LABORATORIES, INC.
A CLIA Certified Laboratory
320 Wakara Way • Salt Lake City, Utah 84108
(800) 469-7423 • (801) 584-1100
Fax (801) 584-3615 • info@myriad.com

COLARIS®

A Test for Lynch Syndrome (HNPCC) and MYH-Associated Polyposis (MAP)

Test Request Form and Statement of Medical Necessity
TO AVOID DELAYS PLEASE COMPLETE ENTIRE FORM

NOTE: Affix Bar Code Label to Specimen Tube

SPECIMEN COLLECTION DATE (REQUIRED): 05/10/2012

ORDERING PHYSICIAN

NAME (LAST, FIRST, DEGREE): Physician, Bob, MD
NPI #: 3456789012
MYRIAD ACCOUNT NO: (If new customer or account number is unknown, please complete the address info or call (800)469-7423): 12345
ADDRESS / CITY / STATE / ZIP:
OFFICE CONTACT: Shirley Assistant
PHONE: 222-222-2222
FAX: 222-222-2223

SEND RESULTS TO (IF OTHER THAN ORDERING PHYSICIAN)

NAME (LAST, FIRST, DEGREE) / NPI #
MYRIAD ACCOUNT NO: (If new customer or account number is unknown, please complete the address info or call (800)469-7423)
ADDRESS / CITY / STATE / ZIP
OFFICE CONTACT / PHONE / FAX

PATIENT INFORMATION (COMPLETE INFORMATION REQUIRED FOR INSURANCE COVERAGE)

PATIENT NAME (LAST, FIRST, INITIAL): Doe, Jane T
PATIENT ID#: 00000
☒ FEMALE ☐ MALE
BIRTH DATE (MM/DD/YYYY): 09/10/1954
STREET ADDRESS: 123 Generic Street
CITY: This City
STATE: ST
ZIP: 45678
DAYTIME PHONE NUMBER: 222-000-0000
E-MAIL ADDRESS: janedoe@email.com

ANCESTRY AND CLINICAL HISTORY

☐ WESTERN/NORTHERN EUROPE ☒ CENTRAL/EASTERN EUROPE ☐ AFRICA ☐ NEAR EAST/MIDDLE EAST
☐ ASHKENAZI ☐ LATIN AMERICAN/CARIBBEAN ☐ ASIA ☐ NATIVE AMERICAN ☐ OTHER _____

PATIENT PERSONAL HISTORY OF CANCER (Check all that apply)

☒ ICD-9 Code(s)/Dx: 153.0, V16.40 (or applicable codes)
☐ No Personal History of Cancer
☒ Colorectal Invasive* Age at Dx: 55 ☒ MSI-H Histology (see below):
☒ Mucinous ☐ Signet Ring ☐ Medullary Growth Pattern
☐ Tumor Infiltrating Lymphocytes ☐ Crohn's-like Lymphocytic Reaction
☐ Adenomatous Polyps Age at Dx of First Adenoma(s): _____
Cumulative #: ☐ 1 ☐ 2-5 ☐ 6-9 ☐ 10-19 ☐ 20-99 ☐ 100+
☐ Endometrial/Uterine Age at Dx: _____
☐ Other: _____ Age at Dx: _____
☐ Bone Marrow Transplant Recipient
*If MSI/IHC testing was performed, please provide results: _____

FAMILY HISTORY OF CANCER (Please Indicate Relationship, Maternal or Paternal, Site of Cancer or Adenoma Number, Age at Diagnosis)

☐ NO KNOWN FAMILY HISTORY

RELATIONSHIP	MATERNAL	PATERNAL	CANCER SITE	AGE AT Dx	ADENOMA NUMBER	AGE AT Dx
Mother	☒	☐	Colon	56		
Aunt	☒	☐	Endometrial	48		
	☐	☐				
	☐	☐				
	☐	☐				
	☐	☐				

TESTS REQUESTED (FOR DETAILED INFORMATION ABOUT THESE TESTS, PLEASE SEE BACK OF THIS FORM)

INITIAL TESTING FOR LYNCH SYNDROME (HNPCC) AND *MYH*-ASSOCIATED POLYPOSIS (MAP)

☒ **COLARIS –** Analysis of *MLH1, MSH2, MSH6, PMS2, MYH,* and *EPCAM (PMS2 and MYH will be reported independently. PMS2 will be billed separately, and coverage may vary based on payor criteria.)*

OTHER TESTS

☐ **SINGLE SITE TESTING** *(For family of known mutation carriers)* **Specify Gene**: _____ and Mutation: _____
Relationship: My patient is the _____ (eg, maternal aunt) of the known mutation carrier. **Include a copy of the known mutation carrier's report, if available.**
☐ **GENE-SPECIFIC TESTING** *(Please specify)*: _____
☐ **OTHER:** _____

INFORMED CONSENT AND STATEMENT OF MEDICAL NECESSITY

I have supplied information to the patient regarding genetic testing and the patient has [illegible] for genetic testing to be performed. I further confirm that this test is medically necessary for the diagnosis or detection of a disease, illness, impairment, symptom, syndrome or disorder, [illegible] be used in the medical management and treatment decisions for the patient. I confirm that the person listed in the Ordering Physician space above is authorized by law to order the test(s) requested.
(NOTE: For Medicare patients, please complete the enclosed Informed Consent Form)
(NOTE: Test requests without a signature will not be processed)

SIGN&DATE

Bob Physician, MD — MEDICAL PROFESSIONAL SIGNATURE
05/10/2013 — DATE

BILLING/PAYMENT INFORMATION

☒ **OPTION 1: PLEASE BILL MY INSURANCE** *(Option 1 requires patient signature and enlarged copy of both sides of insurance card(s). If two cards are submitted, indicate which is primary)*

Name of Policy Holder: JANE DOE DOB: 09/10/1954 Insurance ID #/SSN: ABC-123
Patient Relation to Policy Holder: ☒ Self ☐ Spouse ☐ Child ☐ Other Authorization/Referral #: _____
(Please attach copy of authorization/referral)

I hereby represent that I am covered by insurance and authorize Myriad Genetic Laboratories, Inc. (MGL) to furnish my designated insurance carrier, health plan, or third party administrator (collectively "Plan") the information on this form and other information provided by my healthcare provider necessary for reimbursement. I authorize Plan benefits to be payable to MGL and that MGL will contact me prior to test start ONLY if my total financial responsibility will exceed $375 (for any reason, including co-insurance and deductible[illegible] services). If requested, 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 [illegible]ation to be used in place of the original. I understand that I may not alter any printed text in this paragraph.

SIGN&DATE

Patient/Responsible Party Signature: Jane Doe Date: 05/10/2013

REMINDER: INCLUDE A COPY OF BOTH SIDES OF YOUR INSURANCE CARD(S)

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

☐ Please bill my credit card (all major credit cards accepted) in the amount of $ _____ Card #_____ Exp. Date: _____
Cardholder Name (please print): _____ Cardholder Signature: _____
☐ Personal check, cashiers check, or money order enclosed, payable to Myriad Genetic Laboratories, Inc.

☐ **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 #: _____

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Myriad offers the following tests for Lynch syndrome, also known as Hereditary Nonpolyposis Colorectal Cancer (HNPCC), and *MYH*-Associated Polyposis (MAP):

COLARIS®:

Sequence and large rearrangement analysis of *MLH1*, *MSH2*, MSH6, *MYH*, and *PMS2*,* and large rearrangement analysis of *EPCAM*

NOTE: *MYH* and *PMS2* will be reported independently. *PMS2* will be billed separately, and coverage may vary based on payor criteria.

Single Site Lynch Syndrome Testing:

Mutation-specific analysis for individuals with a known *MLH1*, *MSH2*, *MSH6*, *PMS2, MYH,* or *EPCAM* mutation in the family

Gene-Specific Lynch Syndrome Testing and MAP Analysis:

MLH1 Analysis – Sequence and large rearrangement analysis of *MLH1*
MSH2 Analysis – Sequence and large rearrangement analysis of *MSH2* including *EPCAM* rearrangements
MSH6 Analysis – Sequence and large rearrangement analysis of *MSH6*
PMS2 Analysis – Sequence and large rearrangement analysis of *PMS2*
MYH Analysis – Sequence and large rearrangement analysis of *MYH*

**PMS2* analysis will be run as a reflex test following a negative result for *MLH1*, *MSH2* and *MSH6* for submissions to Medicare and certain other payors.

NOTE: If COLARIS® and COLARIS *AP*® are ordered on the same patient, *MYH* Analysis will only be performed once.