PANEXIA™

Test Request Form and Statement of Medical Necessity

TO AVOID DELAYS PLEASE COMPLETE ENTIRE FORM

SPECIMEN COLLECTION DATE (REQUIRED)

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

NOTE: Affix Bar Code Labels to Specimen Tubes.

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

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

STREET ADDRESS CITY STATE ZIP DAYTIME PHONE NUMBER E-MAIL ADDRESS

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: _____
☐ NO PERSONAL HISTORY OF CANCER
☐ PANCREAS (ADENOCARCINOMA)/AGE AT Dx: _____
☐ BREAST, INVASIVE/AGE AT Dx: _____ ☐ BILATERAL
☐ BREAST, DCIS/AGE AT Dx: _____ ☐ BILATERAL
☐ OVARY/AGE AT Dx: _____
☐ MELANOMA: # OF PRIMARIES: _____ AGE AT EACH Dx: _____
☐ OTHER: _____ AGE AT Dx: _____
☐ BONE MARROW TRANSPLANT RECIPIENT

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

☐ NO KNOWN FAMILY HISTORY

RELATIONSHIP	MATERNAL	PATERNAL	CANCER SITE	AGE AT Dx
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		

TESTS REQUESTED

☐ **Comprehensive PANEXIA**– *PALB2* and *BRCA2* gene sequence analysis for susceptibility to hereditary pancreatic and related cancers.
☐ Perform the following gene analysis **AT THE SAME TIME** as PANEXIA: ☐ *BRCA1** ☐ *p16^*
☐ **REFLEX** to the following if Comprehensive PANEXIA is negative: ☐ *BRCA1** ☐ *p16^*

*Testing done as part of BRAC*Analysis*®
^Testing done with MELARIS®

☐ **Single Site PANEXIA**–Mutation-specific analysis for individuals with a known mutation in their family. **Specify Gene:** ☐ *BRCA2* ☐ *PALB2* ☐ *BRCA1* ☐ *p16*
☐ **Specify Variant (Mutation):** _____ Relationship of known mutation carrier to patient (e.g., sister): _____
☐ **Multisite 3 BRAC*Analysis*®**–Three-mutation *BRCA1* and *BRCA2* analysis for individuals of Ashkenazi Jewish ancestry (187delAG, 5385insC, 6174delT)
☐ **REFLEX** if the Multisite 3 is negative to: ☐ Comprehensive PANEXIA ☐ Other: _____ ☐ **Check** here if a family member is positive for one of the above three mutations
☐ **Other**: _____

INFORMED CONSENT AND STATEMENT OF MEDICAL NECESSITY

I have supplied information to the patient regarding genetic testing and the patient has given consent 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, and the results will 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 herein.

(NOTE: For Medicare patients, please complete the enclosed Informed Consent Form)
(NOTE: Test requests without a signature will not be processed)

_____ Medical Professional Signature _____ 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: _____ DOB: _____ Insurance ID#/SSN#: _____

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. I understand 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, or non-covered 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 this authorization to be used in place of the original.

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

Patient/Responsible Party Signature: _____ Date: _____

☐ **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 number: _____