A tumor test to guide PARP inhibitor treatment decisions

MYRIAD myChoice® CDx PLUS

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AFFIX ONE BAR CODE LABEL HERE

TEST REQUEST FORM

- To avoid delays please complete entire form
- Please print all information in BLOCK LETTERS

PATIENT

Date of Birth (DD-MMM-YYYY): ☐☐ ☐☐☐ ☐☐☐☐	
Gender: ☐ Female ☐ Male	Patient ID:
Last Name:	
First Name:	

ORDERING PHYSICIAN

Last Name:	Degree:
First Name:	Clinical ID:
Institution:	
Street, Nr:	
City, Postal Code:	Day Phone:
Country:	Fax:
E-mail: _____	

BILLING INFORMATION

Payor ID: _____
or
Research #: _____
or
Voucher #: _____

TEST REQUESTED

myChoice Europe - Myriad myChoice® CDx PLUS is used to detect Homologous Recombination Deficiency (HRD) by assessing the Genomic Instability Score (GIS) Status and the Tumor Mutation *BRCA1/BRCA2* Status in genomic DNA extracted from tumor specimens. Results are used as an aid to determine the eligibility of patients with ovarian cancer for treatment with certain Poly-ADP Ribose Polymerase (PARP) inhibitors in accordance with the approved therapeutic product labeling.
Additionally, sequencing and large rearrangement analyses are performed on all analyzable regions of the following genes that have been analytically validated using multiple cancer types: *ATM, BARD1, BRIP1, CDK12, CHEK1, CHEK2, FANCL, PALB2, PPP2R2A, RAD51B, RAD51C, RAD51D,* and *RAD54L*.
For more detailed information on the Myriad myChoice® CDx PLUS test, please refer to the Technical Specifications.

AUTHORIZED SIGNATURE (Physician / Healthcare Provider)

I hereby authorize testing and confirm that informed consent has been obtained from the patient for tissue to be sent to Myriad laboratory in the United States for analysis. I confirm that this test is medically necessary and results will be used in the medical management and treatment decisions for the patient. I hereby declare that the clinical information described on this Test Request Form is correct and belongs to the patient mentioned above. 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 requested herein.

_____ ☐☐ ☐☐☐ ☐☐☐☐
Ordering Physician / Healthcare Provider's Signature — Date (DD-MMM-YYYY)

CLINICAL INFORMATION Please provide the following information:

☐ Ovarian Cancer (Ovary, Fallopian Tube, Peritoneum)
☐ Breast Cancer

Age at Dx: _____ Date of biopsy/surgery (DD-MMM-YYYY): ☐☐ ☐☐☐ ☐☐☐☐

Forward This Test Request Form To The Laboratory Where The Tumor Specimen Is Located.

SPECIMEN INFORMATION: TO BE COMPLETED BY PATHOLOGIST (Complete instructions are in the Preparation and Shipping Instructions sheet)

Samples should ideally contain ***at least 20%*** tumor by pathologic review.
Insufficient tumor DNA content in the provided tumor sample may result in a failure of the GIS Status component of the test.

For a specimen collection set please contact testkit@myriadgenetics.eu

Tissue Type Submitted (e.g. Ovary): _____	ID* _____
☐ Specimen provided is **Fixed Tissue***	
***Only fixed tissues can be tested using Myriad myChoice® CDx PLUS.** Formalin Fixed Paraffin Embedded (FFPE) section(s) are preferred when available, however specimens treated with other fixatives can also be tested.	* Specimen Identification Number as it appears on the tissue blocks or slides submitted to Myriad. **Identifiers provided must match exactly to the sample submitted and the pathology report or testing will be delayed.**

PLEASE NOTE: A COPY OF THE PATHOLOGY REPORT MUST BE SUBMITTED WITH SPECIMEN

TISSUE RETURN

I request the remaining tissue to be returned.*

Name: _____ Address: _____

E-mail / Phone: _____

* If an address is not provided, any tissue remaining after testing will be discarded and not be returnable.

INTERNAL USE ONLY: Bill Institution BIE _____ .

CLEAR

For information or questions regarding Myriad's privacy policy, please visit our website: http://www.myriadgenetics.eu