# A tumor test to guide PARP inhibitor treatment decisions

MYRIAD myChoice® CDx PLUS

myriad WHEN DECISIONS MATTER

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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

**Intended Use** - Myriad myChoice® CDx PLUS is used to detect Homologous Recombination Deficiency (HRD) by assessing the 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.

When ordered as a panel, sequencing and large rearrangement analyses are also 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*. Results from these genes are provided for informational purposes only and have not been clinically validated for use with Poly-ADP Ribose Polymerase (PARP) inhibitors. Follow-up germline testing may be appropriate for mutations in genes associated with hereditary cancer risk.

For more detailed information on the Myriad myChoice® CDx PLUS test, please refer to the Technical Specifications.

| Test Option | Myriad Test Offering (Internal) |
|---|---|
| ☐ Analysis of GIS + *BRCA1/2* | myChoice_BRCA_GIS |
| ☐ Analysis of GIS + *BRCA1/2* + 13 additional genes | myChoice Europe |

## 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 30%*** tumor cells in tissue or fluid samples 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 _____ .

Cancel

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