A tumor test to guide PARP inhibitor treatment decisions

MyChoice® CDx Plus

HRD Companion Diagnostic Test

Myriad genetics

Test Request Form

Myriad Genetic Laboratories, Inc.
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PH: +1 (877) 283-6709 - FX: +1 (801) 883-8998
www.myriad.com
Outside U.S.A
Email: CustomerSupport@myriadgenetics.eu

CE IVD

EC REP
Myriad International GmbH
Nattermannallee 1
50829 Cologne, Germany

Affix one bar code label here

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

Patient

Date of birth (DD-MMM-YYYY): ☐☐ ☐☐☐ ☐☐☐☐	
Sex assigned at birth: ☐ Female ☐ Male	Patient ID:
Legal name (Last):	
Legal name (First):	

Ordering physician

Last name:	Degree:
First name:	Clinical ID:
Institution:	
Street, no:	
City, postal code:	Day phone:
Country:	Fax:
E-mail: _____	

Billing information

Payor ID: _____
or
research #: _____
or
voucher #: _____

Test requested

Intended Use - Myriad Genetics MyChoice® CDx Plus is a next generation sequencing based in vitro diagnostic device that provides sequencing and large rearrangement analyses on a panel of genes and/or detects genomic instability using DNA extracted from tumor specimens. Homologous Recombination Deficiency (HRD) is determined by assessing the results of a subset of these genes and/or the Genomic Instability Score (GIS) Status. The test may be used as a companion diagnostic to identify patients who are or may become eligible for treatment with specific therapies in accordance with the approved therapeutic product labeling. Results are to be used by qualified health care professionals in accordance with professional guidelines in oncology for patients with malignant solid tumors.

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 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): ☐☐ ☐☐☐ ☐☐☐☐
☐ Bone marrow transplant recipient (check if applicable to patient) Type: ☐ Autologous ☐ Allogeneic

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 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

Information

Sex assigned at birth is a label given to an individual at birth, typically "male" or "female".

A legal name identifies a person for legal and administrative purposes. It is recorded on a birth certificate, marriage certificate, or other government issued document that records a name change.

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