THIS TEST IS INAPPROPRIATE FOR TISSUE THAT HAS BEEN PREVIOUSLY TREATED WITH SYSTEMIC THERAPY (E.G. CHEMOTHERAPY OR ENDOCRINE THERAPY) OR RADIATION THERAPY.*
* Refer to the Test Requested section for more detail regarding patient eligibility.

EndoPredict®

Breast Cancer Recurrence Test

myriad® WHEN DECISIONS MATTER

Myriad Genetic Laboratories, Inc.
320 Wakara Way - Salt Lake City, Utah 84108
United States of America
customersupport@myriadgenetics.eu

Myriad Genetics GmbH
Leutschenbachstrasse 95
8050 Zurich - Switzerland
www.myriadgenetics.eu

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): 30 FEB 1900	
Gender: Female	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

EndoPredict - a second generation breast cancer recurrence test that integrates tumor biology and pathology to accurately predict individualized early (0-10 year) and late (5-15 year) distant recurrence risk after 5 years of endocrine therapy, and an absolute chemotherapy benefit. EndoPredict is indicated for women with ER+/HER2- invasive breast cancer with up to 3 positive lymph nodes and tumor size up to pT3 who have NOT been treated with systemic neo-adjuvant therapy and who do not have a current or prior diagnosis of an additional cancer. This test is not appropriate for patients who have already experienced a distant recurrence.

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

30 FEB 1900 Date (DD-MMM-YYYY)

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

CLINICAL/PATHOLOGICAL INFORMATION TO DETERMINE THE EPCLIN RISK SCORE Please provide the following information:

Based on EndoPredict validation, accepted samples for the test are: ER+, HER2-, primary, invasive female breast tumors from patients who have not received systemic endocrine therapy and/or chemotherapy.

☐ Invasive Breast Cancer Age at Dx: _____ Date of biopsy/surgery (DD-MMM-YYYY): 30 FEB 1900

Tumor Size: ☐ pT1a (> 0.1 cm but ≤ 0.5 cm) ☐ pT1b (> 0.5 cm but ≤ 1 cm) ☐ pT1c (> 1 cm but ≤ 2 cm) ☐ pT2 (> 2 cm but ≤ 5 cm) ☐ pT3 (> 5 cm) ☐ pTx

Lymph Node Status: ☐ pN0 (zero positive nodes) ☐ pN1 (1 - 3 positive nodes; excluding pNmi) ☐ pN1mi (>0.2 mm and/or >200 cells but <2mm) ☐ pNx

ER: ☐ negative ☐ positive

HER2 Status: ☐ negative ☐ positive

☐ Patient has received chemotherapy for this diagnosis

SPECIMEN INFORMATION: TO BE COMPLETED BY PATHOLOGIST (Complete instructions are in the Instructions For Use (IFU) sheet).

Paraffin Block with at least 30% of Tumor Tissue:

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

Breast Tissue/Tumor Type: ☐ Post Surgical ☐ Biopsy	ID* _____
Sample Fixative: ☐ 10% neutral buffered formalin ☐ Other:	* 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 _____ .

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

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