myome

MyOme Internal Use Only

TEST REQUISITION FORM

myome Personal Genome™

1. SPECIMEN INFORMATION

Collection Date (MM/DD/YYYY)	Internal Use Only	◯ Blood (two (2) EDTA tubes) ◯ Saliva (2 samples) Send saliva kit to patient? ◯ Yes ◯ No We are unable to accept blood or saliva samples from patients with allogeneic bone marrow transplants or blood transfusion < 2 weeks prior to specimen collection. For a saliva sample, patient may not eat, drink, smoke, chew gum or tobacco 30 minutes prior to sample collection. Pediatric samples require less blood.

2. PATIENT INFORMATION

Name (Last, First, MI)	Date of Birth (MM/DD/YYYY)	Biological Sex ◯ M ◯ F	Patient ID MRN

Email Address	Mobile Phone	Ancestry: ◯ White ◯ Hispanic ◯ Black/African American ◯ East Asian ◯ South Asian ◯ Ashkenazi Jewish ◯ Other:

Address	City	State	Zip

BILLING:

◯ Self-pay ◯ Insurance (fill out information below) ◯ Institutional Billing code, if applicable_____

INSURANCE INFORMATION (attach front and back of insurance card if applicable)

Policy Holder Name	Primary Insurance Company Name	Primary Member ID #	Primary Insurance Phone	Prior-authorization #
Patient Relationship to Policyholder ◯ Self ◯ Spouse ◯ Child ◯ Other:	Secondary Insurance Company Name	Secondary Member ID #	Secondary Insurance Phone	Prior-authorization #

PATIENT ACKNOWLEDGMENT: By my signature, I agree that I have read and agreed to the following and to the Patient Acknowledgment on the back page.

Patient/Guardian Signature (required)	Date (MM/DD/YYYY)

By providing the information included herein, I authorize and consent to MyOme and its affiliates contacting me via e.g. e-mail or cellular or home phone, by text message, automatic telephone dialing system, or computer assisted technology for treatment options, billing/collection matters, and health-related products, services, or studies related to MyOme and its affiliates. I understand that my/my child's treatment, payment, enrollment, or eligibility for benefits is not conditioned on my providing such consent, and I may opt out at any time or by checking this box ☐.

3. ORDERING PROVIDER INFORMATION

Organization Name	Phone	Fax

Address	City	State	Zip

Primary Ordering Provider (Last, First)	NPI	Email
Additional Clinician (Last, First)	NPI	Email
Additional Clinician (Last, First)	NPI	Email

4. TEST MENU (select all that apply)

◯ myome Personal Genome™ Proactive Health Report, 81 Genes

◯ myome Personal Genome™ Pharmacogenomics Report

GENETIC COUNSELING: ◯ Pre-test Genetic Counseling ◯ Post-test Genetic Counseling

CLINICAL PHENOTYPE

Indicate Clinical Phenotype:_____

Ordering Provider Attestation: By signing this form, the medical professional acknowledges that the individual/guardian authorized to make decisions for the individual (collectively, the "Patient") has been supplied information regarding and consented to undergo the genetic testing ordered including genetic counseling by MyOme or its affiliates, substantially as set forth in the Informed Consent for Genetic Testing, and/or as required by applicable law, and the Patient has been informed that MyOme and its affiliates may notify them of clinical updates related to genetic test results (in consultation with the ordering medical professional). For orders originating outside the USA, the Patient has been informed that their personal information and specimen will be transferred to and processed in the USA.

Ordering Professional Signature	Date (MM/DD/YYYY)

Notice of Privacy Practices and information regarding test benefits, risks, and limitations are located at www.MyOme.com/resources

SUPPLEMENTAL INFORMATION

TEST NAME	GENES TESTED
myome Personal Genome™ Proactive Health Report, 81 Genes	*ACTA2, ACTC1, ACVRL1, APC, APOB, ATP7B, BAG3, BMPR1A, BRCA1, BRCA2, BTD, CACNA1S, CALM1, CALM2, CALM3, CASQ2, COL3A1, DES, DSC2, DSG2, DSP, ENG, FBN1, FLNC, GAA, GLA, HFE, HNF1A, KCNH2, KCNQ1, LDLR, LMNA, MAX, MEN1, MLH1, MSH2, MSH6, MUTYH, MYBPC3, MYH11, MYH7, MYL2, MYL3, NF2, OTC, PALB2, PCSK9, PKP2, PMS2, PRKAG2, PTEN, RB1, RBM20, RET, RPE65, RYR1, RYR2, SCN5A, SDHAF2, SDHB, SDHC, SDHD, SMAD3, SMAD4, STK11, TGFBR1, TGFBR2, TMEM127, TMEM43, TNNI3, TNNC1, TNNT2, TP53, TPM1, TRDN, TSC1, TSC2, TTN, TTR, VHL, WT1*
myome Personal Genome™ Pharmacogenomics Report	***CYP2B6**: *4; *6; *9; *18; *22 **CYP2C9**: *2; *3; *4; *5; *6; *8; *11; *12; *13; *15; *16; *26; *28; *29; *30; *31; *42; *55 **CYP2C19**: *2; *3; *4; *5; *6; *7; *8; *9; *10; *17; *35 **CYP2D6**: *2; *3; *4; *5; *6; *7; *8; *9; *10; *11; *12; *14; *15; *17; *21; *29; *31; *40; *41; *42; *49; *56; *59; *100; *114; gene duplications and deletions, **CYP3A4**: *22; *36 **CYP3A5**: *3; *6; *7, **CYP4F2**: *3 **DPYD**: RS3918290; RS55886062; RS59086055; RS67376798; RS75017182+RS56038477; RS112766203; RS115232898; RS146356975; RS183385770 **F5**: RS6025 **IFNL3**: RS12979860 **NUDT15**: *3; *4; *9, **SLCO1B1**: *5; *9; *14; *20 **TPMT**: *2; *3A; *3B; *3C; *4; *11; *29 **UGT1A1**: *6; *27 **VKORC1**: RS9923231*

PATIENT ACKNOWLEDGMENT: By my signature, I agree that I have read and agreed to the following I have been informed, and understand the details of the genetic testing ordered herein by my/my child's health care provider, including the risks, benefits and alternatives and have consented to such testing. I acknowledge that I was offered pre-test genetic counseling, if required by law or reimbursement policy. I understand that the test results may inform me of a medical condition that may require medical follow-up. I also understand that a negative result does not rule out the possibility of such medical condition. If insurance billing is selected, I authorize MyOme or its designees to submit a claim for reimbursement to my/my child's insurer/health plan ("Plan") on my/my child's behalf, with all benefits of the Plan assigned to MyOme or other provider. I understand acceptance of insurance does not relieve me of financial responsibility for the cost of the testing, including, without limit, any copayments, coinsurance or deductibles. If the Plan fails to abide by my assignment, I will remit to MyOme any amounts paid to me directly by the Plan for the testing. I understand the testing may not be covered by the Plan if it is outside of the Plan's coverage guidelines (e.g. where prior authorization is required but not obtained) or deemed not medically necessary – (e.g. experimental) and that I am responsible for costs not paid by the Plan. I irrevocably designate, authorize and appoint MyOme or its designee as my/my child's true and lawful attorney-in-fact for the limited purpose of submitting claims, obtaining a copy of my health plan document, and pursuing any request, disclosure, appeal, litigation or other remedies in accordance with the benefits and rights under the Plan and in accordance with any federal or state laws. The information obtained from my tests may be used in scientific publications or presentations, but my specific identity will not be revealed. MyOme may contact my healthcare provider to obtain more information regarding clinical correlation and confirmatory testing.

SHIPPING INSTRUCTIONS

Please follow instruction in the kit or on the website at www.myome.com/resources to ship specimen in package via FedEx Monday through Thursday.

SHIPPING ADDRESS

ATTN: MyOme Clinical Lab
MyOme, Inc.
1455 Adams drive, Ste 1150
Menlo Park, CA 94025

FAX NUMBER

+1 650-392-3186

