Oncotype DX® Order Form • www.oncotypeiq.com/en

oncotype DX® | EXACT SCIENCES

Territory	Phone	Email
Canada	1-866-662-6897	international@exactsciences.com
Asia Pacific & Latin America	+1-650-569-2080	international@exactsciences.com
Middle East & Africa	+41-22-715-29-00	europeansupport@exactsciences.com

Study Information/Code. _____

For supported local numbers please see back of form or visit www.oncotypeiq.com/en

SECTION I. TEST & CLINICAL INFORMATION

Invasive Breast Cancer

☐ **Oncotype DX Breast Recurrence Score® Test** for Invasive Breast Cancer Patient

ER STATUS:
☐ Positive
☐ Negative
☐ Inconclusive by IHC
☐ Not tested

NODAL STATUS:
☐ Negative
☐ Micromets pNmi (0.2-2.0mm)
☐ Positive 1-3
☐ Positive 4-9
☐ LN Not Tested

MENOPAUSAL STATUS*
*required for positive nodal statuses (N1mi or 1-3 nodes)
☐ Postmenopausal
☐ Premenopausal
☐ Unknown

Ductal Carcinoma in Situ

☐ **Oncotype DX Breast DCIS Score® Test**

Tumor Size (cm): _____ ▪ _____

Patient Age at Diagnosis:
☐ Less than 50 years of age
☐ Greater than or equal to 50 years of age

Provide accurate tumor size based on excisional biopsy pathology report. Missing or inaccurate tumor size will impact the risk estimates on the report, and you may be contacted.

Colon Cancer

☐ **Oncotype DX Colon Recurrence Score® Test**

Select patient stage:

☐ **Stage II Patient**
(T3 or T4) AND Node Negative
(for known MMR Proficient tumors)

☐ **Stage III A/B Patient**
Any T AND 1-3 Positive Nodes

SECTION II. ORDERING PROVIDER & PATHOLOGY

Ordering Provider First Name, Last Name
Phone Fax
Email
Institution
Street Address
City Province
Post Code Country
Office Contact Name & Email

Pathologist First Name, Last Name
Phone Fax
Email
Institution
Street Address
City Province
Post Code Country
Office Contact Name & Email

Additional Provider (Optional)

Additional Provider First Name, Last Name
+662 938 9099 -
Phone Fax
service@biostem.co.th
Email
BioStem Co., Ltd.
Institution
599/15-17 Srinakarin Rd.,
Street Address
Muang Samutprakan Samutprakan
City Province
10270 Thailand
Post Code Country
Office Contact Name & Email

SECTION III. PATIENT INFORMATION

Patient First Name, Last Name/Patient ID
DOB (DD/MM/YYYY) ☐ Female ☐ Male
Street Address, City
Province Postal Code Country
Phone E-Mail

SECTION IV. BILLING AND DIAGNOSIS

Please select ONE billing or payment option and complete the form (See reverse for details.)

Submitting Diagnosis ICD-10 Code

Select one billing option:
1) ☐ **Insurance**
2) ☐ **Institution/Hospital** (Restricted to contracts on file with GHI.)
3) ☐ **Patient**

Please complete below for bill insurance or institution option & attach copy of insurance card.

Insurance or Institution
Patient Insurance Number Insurance Authorization Number

SECTION V. SPECIMEN INFORMATION (Required) — No substitutions for this assay

Specimen Retrieval

☐ 1) Exact Sciences to request specimen on my behalf

Location of Specimen Phone Fax

☐ 2) Ordering Provider to request specimen

Multiple Primaries

Is more than one primary tumor being submitted for testing? ☐ Yes ☐ No

Specimens will be processed sequentially as listed below.

Specimen ID/Case Number Only one specimen is typically required. For multiple primaries, list the most aggressive tumor first.	Specimen Barcode	Date of Surgery (DD/MM/YYYY)
1) _____		1) _____
2) _____		2) _____

SECTION VI. PROVIDER SIGNATURE & SPECIMEN STATUS

Provider Signature (Required)
Date (DD/MM/YYYY)

Your signature confirms that you have read and accept the terms stated on the reverse side. Specifically by signing this form you are stating that either 1) the patient meets the criteria stated on the reverse side of this form OR 2) if the patient does not meet these criteria, that you have selected the exceptions as they apply or indicated them in the Exception Criteria space below. GHI may contact you should your patient not meet these criteria.

Block Return Location: (Leave blank if submitting slides)

Contact Name Phone Address

Specimen Comments/Exception Criteria (See reverse for definition)