

## Ordering Physician

## Patient Information

Name:  First  Last

Address:

City:  State:  Zip:

Date of Birth:  Month  Day  Year  Phone:

MRN/Patient ID:

### 1. Test Ordered:

☒ Genomic Prostate Score for Localized Prostate Cancer

### 2. Clinical Information: (Please provide a copy of pathology report, history & physical, and office/progress notes with test order)

PSA:  ng/mL Prostate Volume (mL):

Prostate Biopsy:  Specimen ID:  Collection Date:  Month  Day  Year

MRI Targeted Biopsy ☐ Yes ☐ No

# of Cores Collected:  Gleason Score (highest grade):  3+3=6  3+4=7  4+3=7  Clinical Stage:  T1a  T1b  T1c

# of Positive Cores:  4+4=8  3+5=8  4+5=9  T2a  T2b  T2c

Max % tumor involvement in any core ≤50% ☐ Yes ☐ No  T3a

### 3. GPS Specimen Request:

☐ I want mdxhealth to request the specimen. Mdxhealth will obtain the patient's prostate biopsy from the Pathology Laboratory. Send signed requisition, pathology report, and patient's insurance information to cs@mdxhealth.com.

Path Lab Name:

### 4. Required Billing Information: (ICD-10, copy of insurance card, and pathology report required)

ICD-10 Code(s):  C61 Malignant neoplasm of prostate  Other:

Select Payment Type: ☐ Private Insurance ☐ Medicare ☐ Medicaid ☐ Patient Self-Pay ☐ Client (contract required)

Name of Insurance:  Member ID:

(Medicare only) Was procedure performed in hospital? If yes: ☐ hospital outpatient ☐ hospital inpatient - discharge date  Month  Day  Year

Include copies of both sides of insurance card(s). If two cards are submitted, indicate which is primary.

### 5. Authorization and Statement of Medical Necessity:

I hereby authorize testing and confirm that an informed consent has been obtained, if required by state law. I confirm that this is medically necessary and the results will be used in the medical management decisions for the patient. I confirm that the patient has an estimated life expectancy of greater than or equal to 10 years. 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. I confirm that I have on file the patient's assignment of benefits authorizing insurance benefits to be paid to ancillary healthcare service providers, such as mdxhealth, Inc. I further instruct mdxhealth to retain this completed test requisition as part of the patient medical record. I authorize mdxhealth to release the information on this form, and other information provided by me, or on my behalf, necessary to process a claim for this service.

**For Medicare and Medicare Advantage Beneficiaries:** Prior to ordering, I certify that the patient meets the Medicare eligibility criteria provided on the back side of this form.

Ordering Physician Signature (No stamped signatures)  Date  Month  Day  Year

Submitting this form constitutes a Certification of Medical Necessity and a certification that you have obtained consent for Mdxhealth Inc. to release the test results and relevant medical information to the patient's insurance carrier as part of the coverage and reimbursement process.

PLEASE KEEP A COPY AND RETAIN IN PATIENT'S MEDICAL RECORD

Mdxhealth Internal Use Only: Total Pages:  Blocks:  Slides:

## Medicare Coverage Indications for Genomic Prostate Score

### GPS is covered for men with prostate cancer:

With localized or biochemically recurrent adenocarcinoma of the prostate (i.e., no clinical evidence of metastasis) who have a life expectancy of greater than or equal to 10 years if they are a candidate for and are considering (or being considered for) at least one of the following:

- Conservative management and yet would be eligible for definitive therapy (radical prostatectomy (RP), radiation or brachytherapy), or;
- Radiation therapy and yet would be eligible for the addition of a brachytherapy boost, or;
- Radiation therapy and yet would be eligible for the addition of short-term androgen deprivation therapy(ADT), or;
- Radiation therapy with short-term ADT yet would be eligible for the use of long term ADT, or;
- Radiation with standard ADT yet would be eligible for systemic therapy intensification using next generation androgen signaling inhibitors or chemotherapy, or;
- Observation post-prostatectomy yet would be eligible for the addition of post-operative adjuvant radiotherapy, or;
- Salvage radiotherapy post-prostatectomy yet would be eligible for the addition of ADT.

### The following criteria must also be met for coverage:

- The assay is performed on formalin-fixed paraffin embedded (FFPE) prostate biopsy tissue with at least 0.5 mm of linear tumor diameter or FFPE tissue from a prostate resection specimen, and;
- Result will be used to determine treatment according to established practice guidelines, and;
- Patient has not received pelvic radiation or ADT prior to the biopsy or prostate resection specimen, and;
- Patient is monitored for disease progression according to established standard of care.

**NOTE:** Third-party reimbursement is affected by many factors. Mdxhealth makes no representation or guarantee that full or partial insurance reimbursement or any other payment will be available. While mdxhealth tries to provide correct information, we make no representations or warranties, expressed or implied, as to the accuracy of the information. These support services have no independent value to providers and are included within the cost of the Genomic Prostate Score testing services.