impact genetics

Rev 10May2024 (CAN/INT'L/US/LabCorp)
LabCorp Test #480344

Uveal Melanoma

Prognostic Genetic Test

1. Forms

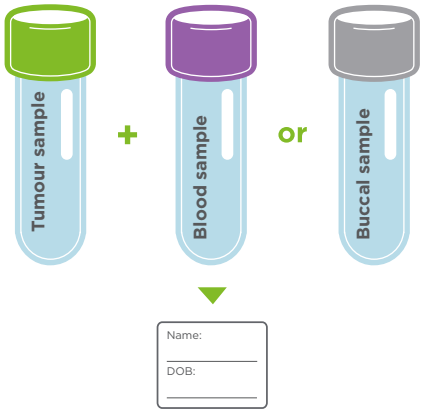
1a Informed Consent

1c U.S. Insurance Information **if applicable** (U.S. patients only) + Supporting insurance documents

1b Requisition

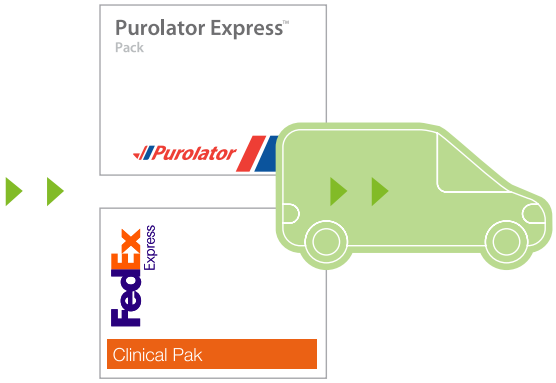
1d Credit Card Authorization **if applicable** (Canada and international patients only)

2. Samples



Ensure samples are labelled with at least 2 patient identifiers **(full name and DOB)**

3. Ship



Impact Genetics, Dynacare
115 Midair Court
Brampton, ON L6T 5M3
t 877.624.9769

Results

3 to **6** weeks
sample processing to report

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Form 1a: Informed Consent to Perform Genetic Testing for Uveal Melanoma

The purpose of my DNA test is to look for variant(s) known to be associated with prognosis for survival in patients with uveal melanoma. I understand this test requires tumor and buccal (or other normal) samples for use in prognostic testing.

By signing below, I acknowledge that:

1. My participation in this DNA testing is voluntary. The decision to consent to, or to refuse the above testing is entirely mine.
2. This testing is done on small biological samples.
3. It is possible that the quantity or quality of sample submitted may be inadequate for testing.
4. I understand that prognostic genetic tests for uveal melanoma are not entirely predictive. Patients with a good prognosis can develop metastatic disease (albeit rarely) and vice versa.
5. Impact Genetics will only collect, use, and disclose your personal health information as permitted/designated on the requisition/order form or required by applicable laws. For example, if necessary to obtain reimbursement of test fees, Impact Genetics, its agents and legal representatives, may disclose personal health information (including test results) for such purpose.
6. Impact Genetics is not a DNA banking facility and patient DNA samples may not be available for future testing.
7. There is a chance that the test may reveal unexpected abnormalities that may be of medical value in the patient's care. Impact Genetics will inform the referring specialist designated on the requisition/order form.
8. Until the results of this test are reported, the patient and members of the patient's family should still undergo examinations as prescribed by the referring specialist.
9. I have read or have had read to me, the above information and I understand it. I have also read or had explained to me the specific disease or condition tested for, and the specific test(s) I am having, including the test descriptions, principles and limitations. I have had the opportunity to discuss the purposes and possible risks of this testing with my doctor or someone my doctor has designated.

Signature of patient:_____ Date:_____

Signature of witness:_____ Date:_____

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Form 1a: Informed Consent to Perform Genetic Testing for Uveal Melanoma (NY)

The purpose of my DNA test is to look for variant(s) known to be associated with prognosis for survival in patients with uveal melanoma. I understand this test requires tumor and buccal (or other normal) samples for use in prognostic testing.

By signing below, I acknowledge that:

1. My participation in this DNA testing is voluntary. The decision to consent to, or to refuse the above testing is entirely mine.
2. This testing is done on small biological samples.
3. It is possible that the quantity or quality of sample submitted may be inadequate for testing.
4. No tests other than those authorized shall be performed on this biological sample.
5. I understand that prognostic genetic tests for uveal melanoma are not entirely predictive. Patients with a good prognosis can develop metastatic disease (albeit rarely) and vice versa.
6. Impact Genetics will only collect, use, and disclose your personal health information as permitted/designated on the requisition/order form or required by applicable laws. For example, if necessary to obtain reimbursement of test fees, Impact Genetics, its agents and legal representatives, may disclose personal health information (including test results) for such purpose.
7. Impact Genetics is not a DNA banking facility and patient DNA samples may not be available for future testing.
8. There is a chance that the test may reveal unexpected abnormalities that may be of medical value in the patient's care. Impact Genetics will inform the referring specialist designated on the requisition/order form.
9. Until the results of this test are reported, the patient and members of the patient's family should still undergo examinations as prescribed by the referring specialist.
10. I have read or have had read to me, the above information and I understand it. I have also read or had explained to me the specific disease or condition tested for, and the specific test(s) I am having, including the test descriptions, principles and limitations. I have had the opportunity to discuss the purposes and possible risks of this testing with my doctor or someone my doctor has designated.

Consent for Storing a Sample

Impact Genetics is not a DNA banking facility and patient DNA samples may not always be available for future testing. However, Impact Genetics has my consent to store any surplus DNA samples indefinitely, for future clinical testing as requested by me. If "No" is checked or if neither box below is checked, the sample will be destroyed within 60 days after test completion.

☐ **Yes** ☐ **No**

Signature of Patient or Consenting Parent/Guardian: _____ Date: _____

Signature of Witness: _____ Date: _____

Statement of Referring Physician

I reviewed this form with my Patient. I offered to answer any questions.

Signature of Referring Physician: _____ Date: _____

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Information About the Uveal Melanoma Prognostic Genetic Test

What is Uveal Melanoma?

Uveal melanoma (UM) is a melanoma (type of cancer) of the eye, involving the iris, ciliary body or choroid (collectively referred to as the uvea). These malignant (cancerous) tumours arise from the pigmented cells (melanocytes) within the uvea.

Purpose and Principle of the Test

Approximately 50% of patients diagnosed with UM will develop metastases within 10 years of treatment of the primary intraocular tumour. Multiple factors contribute to the survival prognosis of a patient with uveal melanoma including genetics of the tumour, histologic grade, size and clinical stage of the tumour *[Damato, B. et al. Progress in Retinal and Eye Research, 2011]*.

One of the most important indicators of poor prognosis in UM is loss of chromosome 3 (monosomy 3). Metastatic disease develops almost exclusively in patients with this genetic abnormality. Other genetic factors contributing to the survival prognosis include copy number variation of chromosomes 1, 6 and 8 *[Damato, B. and Coupland, S.E. Arch Ophthalmol. 2009]*. The prevalence of monosomy 3 in small tumours (basal diameter <10 mm) is as high as 35% *[Damato, B. and Coupland, S.E. Arch Ophthalmol. 2009]*. For this reason, it is important to analyze the genetics of the tumour in addition to other factors such as size.

Cancer is often unpredictable and many patients find it difficult to come to terms with a diagnosis of cancer. Sharing this information with family members and friends can be very challenging. Some patients feel, however, that knowing their chance of survival is valuable. This knowledge empowers life planning and may initiate the development of support strategies. Many individuals diagnosed with this condition state that they have hope they will be considered to be at low risk for the cancer to spread; however, knowing either way can allow them to understand more clearly their risk for the future. If cancer spreads to the liver, there is limited treatment available to cure it at this time.

Some specialists will change treatment and/or surveillance for metastases depending upon the genetic make-up of cancer cells (determined through genetic prognostic testing).

Test Method: Impact Genetics' Mutation Identification Strategy

Fresh tumour sample is obtained from the affected eye either by a biopsy at the time of radiation plaque therapy or taken directly from the removed (enucleated) eye by a pathologist. Frozen tumour samples or banked tumour DNA can also be submitted for analysis. In addition, a blood or buccal sample is required and used for comparison analysis. Impact Genetics isolates DNA from the specimens provided (unless provided DNA directly) and performs molecular tests to identify the chromosomal alterations in the tumour DNA. The results from testing can be used to predict if these tumour cells have a high or low risk to metastasize and can be used in the design of appropriate surveillance and treatment plans and for life planning.

Impact Genetics is certified under the US Clinical Laboratory Improvement Amendments of 1988 (CLIA-88) as qualified to perform high complexity clinical laboratory testing. Impact Genetics's tests were developed, and their performance characteristics determined, by Impact Genetics. They have not been cleared or approved by the US Food and Drug Administration, which has determined that such approval is not necessary. Impact Genetics does not perform linkage analysis.

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Lab Use Only. Do not fill out.
Date received: Y M D
Specimen type:
Condition:
Lab #: Tech:

LabCorp Account #:
U.S patients only

Form 1b: Uveal Melanoma Prognostic Genetic Test Requisition **LabCorp test #480344**

Ordering Options

☐ **Uveal Melanoma Prognostic Genetic Test**

Patient

Legal last name:
Legal first name:
Preferred first name (if applicable):
Date of birth: Y M D
Sex at birth: ☐ **Male** ☐ **Female** ☐ **Other** specify:
Gender identity: ☐ **Same as sex at birth**
☐ **Different than sex at birth** specify:
Address:
City: Prov/State:
Postal/Zip code: Country:
Phone:
Ethnicity:
Pigmentation:
Skin colour: Eye colour:
Hair colour:

Specimen Information

Tumour sample—fresh tumour in cell lysis
(required in an Impact Genetics collection tube):
☐ **FNAB sample**
☐ **Enucleation biopsy sample**
☐ **Other** specify:
Date of collection: Y M D

Normal/control sample **(required)**:
☐ **Blood** (one EDTA lavender top tube or 1 yellow top ACD tube)
☐ **Buccal swab** (in an Impact Genetics collection tube)
☐ **Other** specify:
Date of collection: Y M D

Histology

Tumour thickness*(by ultrasound, mm):
Largest basal tumour diameter*(LBD, mm):
Anatomic sub-classification:
☐ **Choroid** ☐ **Iris** ☐ **Ciliary body involvement**
☐ **Other** specify:
Extraocular extension (spread) present:
☐ **Yes, greater than 5 (>5)** ☐ **Yes, less than or equal to 5 (≤5)**
☐ **No**
Mitotic count: per HPF
Closed loops: ☐ **Yes** ☐ **No**
Epithelioid cells: ☐ **Yes** ☐ **No**
AJCC TNM stage:
***These values are required for TNM survivorship prediction.**

Patient History

Diagnosis Date: Y M D
Type of primary management:
☐ **None** ☐ **Proton beam radiotherapy** ☐ **Enucleation**
☐ **Plaque therapy** ☐ **Other** specify:

Referring Specialist

Name:
Specialty:
Contact:
Phone: Fax:
Email:
Signature:
Institution:
Address:
City: Prov/State:
Postal/Zip code: Country:
Additional copies to:
Email:
Fax:

Billing

☐ **Institution**
Provide details:

☐ **Patient pay**
Complete **Form 1d:** Credit Card Authorization for Non-Covered Services **(Canada and international patients only)**.

☐ **OHIP card #:**
Provide 12-digit Ontario Health Card number, above **(Ontario residents only)**.

☐ **Third party insurance (U.S. patients only)**
Complete **Form 1c:** U.S. Insurance Information.

Ordering Specialist: By submitting this form, I confirm that this test is being ordered for the purpose of prognosis as per the **Laboratory and Specimen Collection Centre Licensing Act** (Ontario, Canada).

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115 Midair Court, Brampton, ON L6T 5M3
t 647.478.4902 or 877.624.9769 **f** 905.697.9786
e impactgenetics@dynacare.ca
Please ensure to use secure email.

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Form 1c: U.S. Insurance Information **(U.S. patients only)**

Impact Genetics is committed to providing the highest quality genetic testing to all patients.
In many situations, genetic testing improves outcomes and quality of life and decreases total costs to the patient and healthcare system.

Processing medical insurance claims is usually challenging and time consuming. Many insurance companies require pre-authorization prior to testing. Impact Genetics supports insurance billing via LabCorp, completing coverage checks and pre-authorization.

It is important for patients to understand that insurance may not cover 100% of the cost of genetic testing and they may be financially responsible for some of all of the cost of testing. The patient is responsible for any portion of the test fee not covered by insurance for any reason, including but not limited to, co-payments, unmet deductibles, co-insurance and non-covered services. Prior determinations do not guarantee payment and the amount paid by insurance when the claim is submitted may be different from the coverage indicated during the pre-verification or pre-authorization process.

Pre-authorizations can take time to obtain depending on each individual insurance plan's policy and documentation requirements. Turnaround time for test results begins after the pre-authorization has been processed and approved.

Insurance process

1. Send **Form 1c**: *U.S. Insurance Information* as soon as possible.
2. Insurance coverage will be investigated and the patient will be contacted to provide coverage estimate if the patient's out-of-pocket costs are over $300.00.
3. Insurance claim will be submitted upon completion of testing.
4. After insurance payment is received patient will be billed for non-covered services.

Note: Timely and complete submissions will enable faster insurance checks.

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Send this form to Impact Genetics
by fax to 905.697.9786

Form 1c: U.S. Insurance Information

Uveal Melanoma Prognostic Genetic Test

Disease/Genetic Test

☐ **Uveal Melanome Prognostic Genetic Test**
(LabCorp test #480344)

ICD-10 Code • provide code here ▸ _____

CPT Codes: 81294, 81403, 81406, 81479, 81301

Insurance Information

☐ **Primary insurance** ☐ **Secondary insurance**

If patient has secondary insurance, include the information on an additional copy of this form with the secondary insurance box checked.

Name of insured (if not patient):

_____

Insurance company: _____

Claims address: _____

_____

City: _____

State: _____ Zip code: _____

Country: _____

Group #: _____

Subscriber/member #: _____

Physician Information

Physician's name: _____

NPI: _____

Practice name: _____

Practice address: _____

_____

Phone: _____

Fax: _____

Patient Information

Last name: _____

First name: _____

Date of birth: Y M D _____

Address: _____

_____

City: _____

State: _____ Zip code: _____

Country: _____

Phone: _____

Contact Information

Details of insurance coverage will be communicated directly to patient. Please provide patient contact info:

Phone: _____

Alternate phone: _____

Email: _____

☐ **In the event Patient cannot be reached, a voice message related to uveal melonoma prognostic genetic testing may be left at the above phone number(s).**

Please Attach **All** of the Following

- Copies of both the front and back of insurance membership card(s)
- Letter of Medical Necessity, signed by Referring Specialist (contact Impact Genetics for template if needed)
- Clinic notes demonstrating the Patient's need for testing and confirmation of diagnosis
- Insurance approval details **if** prior authorization already completed

Performing lab:

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115 Midair Court, Brampton, ON L6T 5M3
t 647.478.4902 or 877.624.9769 **f** 905.697.9786
e impactgenetics@dynacare.ca
Please ensure to use secure email.

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Please do not send form with sample:
Send this form to Impact Genetics
by fax to 905.697.9786
or call 647.478.4902/1.877.624.9769
For patient pay, testing will be held pending receipt of this completed form.

Form 1d: Credit Card Authorization for Non-Covered Services

(Canada and international patients only)

To be completed by and returned to Impact Genetics directly by the cardholder.

Laboratory Test

- ☐ **Retinoblastoma Genetic Test**
- ☐ **Uveal Melanoma Prognostic Genetic Test**
- ☐ **HHT Genetic Test**
- ☐ ***MLH1/MSH2/MSH6/PMS2/EPCAM* Somatic Tumour MMR Sequencing and Deletion/Duplication Test**

Billing Information

Patient name: _____ Date of birth: Y M D

☐ **Visa** ☐ **MasterCard**

Name on card: _____

Billing address: _____

City: _____ Province/State: _____

Postal/Zip code: _____ Country: _____

Card #: _____ Expiration date: _____

CVC # (3-digit Card Verification Code on back of card): _____

Contact Information

Please provide at least 2 contact methods and check preferred:

- ☐ Phone: _____
- ☐ Email: _____
- ☐ Fax: _____

Statement of Financial Responsibility

Box below must be checked for testing to proceed.

☐ **I understand that my health coverage plan is not expected to pay for these test(s) at 100% and I agree to be personally and fully responsible for payment.**

Cardholder's signature: _____ Date: _____

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Step 2: Sample Preparation Instructions

Uveal Melanoma Prognostic Genetic Test

Kit Contents (provided by Impact Genetics)

- One tube with cell lysis for tumour sample
- One tube with cell lysis for buccal swab sample
- *Buccal Swab Collection Instructions* sheet
- *Buccal Swab Patient Information Form*
- One sterile cytology brush for buccal swab collection
- Plastic bag to place samples in
- Absorbent pad for shipping
- Rigid box for shipping
- Patient labels

Kits are provided with an expiry date. For replenishment of supplies contact Impact Genetics at least two weeks in advance of need.

Samples Required (both tumour and normal sample required)

- **Normal sample:** buccal swab or blood sample
- **Tumour sample:** tumour biopsy (FNAB or other)

Sample Preparation Instructions

Normal sample:

- **Blood samples for DNA:**
  10mL venous blood in yellow-topped ACD tube or lavender-topped EDTA tube at room temperature, to be received within 5 days after draw.

or

- **Buccal swab:**
  Refer to *Buccal Swab Collection Instructions* document.

+

Tumour sample:

- **Fine Needle Aspirate Biopsy (FNAB):**
  Place FNAB sample in the collection tube labelled "*Tumour*" (provided). Two or more FNAB passes are preferred and all passes can be combined in the same "*Tumour*" collection tube (provided). **Do not fix** the tissue.

or

- **Biopsy:**
  If possible, larger tumour tissue samples from a biopsy are preferred. Place the fresh tumour sample in the "*Tumour*" collection tube (provided). **Do not fix** the tissue.

- Once the tumour sample is in the tube, place the twist top cap on the tube and firmly tighten to close.
- Label the collection tube with one of the stickers (provided), complete with the patient full name (first and last) and date of birth of the patient from whom the tumour sample was obtained.
- Place the tube inside the plastic biohazard bag and seal the bag. Leave the absorbent pad in the plastic bag.
- Tumour sample tube can be stored at room temperature or refrigerated (2-8 °C) until shipping. **Do not freeze**.

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Buccal Swab Collection Instructions

1. The person providing the buccal cell samples should **not** eat, drink, smoke, clean their teeth or use mouthwash 1 hour before sample collection.
2. The person taking the samples should thoroughly wash their hands prior to collecting the sample.
3. Open the OmniSwab packaging at the handle end and carefully remove the swab. **Do not touch** the collection pad (soft side) of the swab.
4. Holding the handle end of the OmniSwab, scrape the collection pad (soft side) firmly against the inside of the cheek 5–6 times (for around 10 seconds). Be careful not to eject the tip. *See Figure 1.*

Figure 1

Scan QR code to view a short video demonstrating the OmniSwab collection method.

5. After taking the sample, eject the tip into the tube labelled "*Buccal*" (provided) by firmly pressing the plunger at the end of the handle. After ejecting the tip into the lysis tube, dispose of buccal swab handle according to local regulations.
6. Once the buccal sample is in the tube, place the twist top cap on the tube and firmly tighten to close.
7. Label the buccal tube with one of the stickers (provided) with full name (first and last) and date of birth of the patient from whom the buccal sample has been collected.
8. Place the tube inside the plastic biohazard bag and seal the bag.
9. Complete the *Buccal Swab Patient Information Form*. Fold and place in the external pouch of the plastic biohazard specimen bag. Then place specimen biohazard bag into rigid container (provided).
10. Once collected, the buccal sample tube is stable when stored at room temperature or refrigerated (2-8 °C) for several days. However we recommend sending the buccal sample as soon as possible to ensure specimen integrity and to expedite your test results.

Notes:

- To ensure a safe experience during buccal sample collection, follow instructions above.
- If the swab becomes contaminated through touch or contact with an unclean surface do **not** proceed to use the swab for sample collection. Contact us directly to request an additional buccal collection kit.
- If the contents of the tube are spilled prior to or after buccal collection continue with sample collection steps above and add this information to the *Buccal Swab Patient Information Form*.
- The tube provided for buccal collection contains "Cell Lysis Solution" provided by Qiagen GmbH. This cell lysis solution is considered non-hazardous. For more information, visit: **https://www.qiagen.com/de-us/knowledge-and-support/product-and-technical-support/quality-and-safety-data/sds-search**.

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Buccal Swab Patient Information Form

This form is to be completed by the person who has performed the buccal swab collection. Once completed, fold and place this form in the outside pouch of the biohazard plastic bag containing the buccal sample.

Patient Information

First name: _____ Last name: _____

Date of birth: Y M D _____ Date of collection: Y M D _____

Sample Collection Comments

1. Did the buccal swab collection pad (soft side) potentially come in contact with hands or other surfaces?

   ☐ **Yes** ☐ **No**

   If *Yes*, please describe: _____

_____

_____

_____

2. Was any cell lysis solution lost from the specimen tube provided?

   ☐ **Yes** ☐ **No**

   If *Yes*, please describe: _____

_____

_____

_____

Signature: _____ Date: _____

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Step 3: Shipping Instructions

For shipping inquiries and notifications, please contact:

impact genetics
email: info@impactgenetics.com
phone: 647.478.4902 or 877.624.9769
fax: 905.697.9786

General Shipping Instructions

- If you have more than one patient request to submit, multiple patients can be sent in the same shipment.
- Submit specimen(s) for each patient in a biohazard specimen bag, **only one patient's specimen(s) per bag**. Refer to **Step 2:** *Sample Preparation Instructions* for shipping conditions.
- Include informed consent and requisition forms (**Form 1a** and **1b**) as well as any required clinical documents along with the samples. Place documents in a separate pouch or bag. **Do not** place documents inside the biohazard bag with specimens.
- Samples coming from the U.S. must also include U.S. insurance information (**Form 1c**) if required and **not** provided previously.
- Provide us with the parcel tracking number by phone or email shortly after courier pickup.
- For emailed PDF FedEx waybills and customs forms, please contact us directly.

Instructions for Specimens from Outside of Canada

- DNA studies: select **FedEx International Priority**
- RNA studies for *RB1*, **or** prenatal studies on direct amniotic fluid or CVS sample,: select **FedEx International Priority Express** (contact Impact Genetics before sending)
  - Samples **must** be received within 48 hours of collection
- Samples coming from outside of Canada **must** submit a waybill and commercial invoice:
  - Print **one** copy of the waybill and **three** copies of the commercial invoice
  - Sign each commercial invoice and place with the waybill in the external document pouch
- When preparing documentation:
  - Declare a value of $10.00
  - Declare as "*Exempt Human Diagnostic Specimen(s)*"
  - Description of Goods: *Human (blood/tissue) specimen for testing in a clinical laboratory. The enclosed material(s) are not zoonotic, are not of tissue culture origin, and are not known or suspected to contain an etiological agent, host, or vector of human disease.*

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Step 3: Shipping Instructions (continued)

Instructions for Specimens from Within Canada

- DNA studies: select **Purolator Express** (next-day) or **FedEx Priority** (overnight)
- RNA studies for *RB1*, **or** prenatal studies on direct amniotic fluid or CVS sample: select **FedEx First Overnight** (contact Impact Genetics before sending)
  - Samples **must** be received within 48 hours of collection
- When preparing documentation:
  - Declare a value of $10.00
  - If required, declare as "*Exempt Human Diagnostic Specimen(s)*"