DECIPHER BIOSCIENCES

POST-TEST TREATMENT - FORM 2

DECIPHER® CERTIFICATION AND TRAINING REGISTRY (DECIPHER CTR)

Date: ____/____/_____
MM / DD / YYYY

Patient's Name: _____ Date of Birth: ____/____/_____ Physician's Name: _____
MM / DD / YYYY

Physician's Address: _____ City: _____ State: _____ Zip: _____

Local Coverage Decision (LCD) L36343 requires that healthcare providers who are registered in the Decipher Prostate Cancer Classifier Certification and Training Registry (Decipher Prostate Cancer Classifier CT R) collect an d re port data to CMS MolDx contractor on those Medicare patients tested under the Decipher Prostate Cancer Classifier CTR.

This Post-Test Treatment form is provided in order to capture treatment administered to the Medicare patients after Decipher test results have been provided to the physician.

Decipher has agreed to receive these reports for the purpose of reporting to CMS MolDx contractor on your behalf in compliance with the LCD. To protect the confidentiality of protected health information (PHI), all data collected will be de-identified and aggregated for reporting to CMS MolDx contractor. If you have any questions, you may contact Customer Support at 1.888.792.1601.

Accession #: _____ Date of Last Follow Up: ____/____/_____
MM / DD / YYYY

1. Physician treatment recommendations physician and patient agreed upon (post-Decipher testing):

- ☐ Observation with PSA Monitoring
- ☐ Adjuvant RT
- ☐ Salvage RT
- ☐ Adjuvant RT + ADT
- ☐ Salvage RT + ADT
- ☐ ADT Alone
- ☐ Adjuvant ADT
- ☐ Other: _____

2. Did the patient comply with Management Plan? Select

Please explain:

To the best of my knowledge, the information above is accurate.

_____ _____ ____/____/_____
HEALTHCARE PROVIDER NAME (PRINT NAME) HEALTHCARE PROVIDER SIGNATURE DATE (MM/DD/YYYY)

NPI #: _____ Healthcare Provider Phone: (____) ____ - _____ Email: _____

PLEASE FILL OUT THE FORM ABOVE AND RETURN THE SIGNED COPY VIA DOCUSIGN, FAX (1.855.324.2768) OR EMAIL (CUSTOMERSUPPORT@DECIPHERBIO.COM)

FOR QUESTIONS, CALL CUSTOMER SUPPORT AT 888.792.1601, OPTION 8

Testing is performed by Decipher Corp., a Decipher Biosciences company

DECIPHER CORP.
10355 SCIENCE CENTER DRIVE, SUITE 240, SAN DIEGO, CA 92121
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DECIPHER BIOSCIENCES

ADVERSE EVENT REPORT (AER) - FORM 3

DECIPHER CERTIFICATION AND TRAINING REGISTRY (DECIPHER CTR)

Date: ____/____/_____
MM / DD / YYYY

Patient's Name: _____ Date of Birth: ____/____/_____ Physician's Name: _____
MM / DD / YYYY

Physician 's Address: _____ City: _____ State: _____ Zip: _____

Local Coverage Decision (LCD) L36343 requires that healthcare providers who are registered in the Decipher Prostate Cancer Classifier Certification and Training Registry (Decipher Prostate Cancer Classifier CTR) collect and report data to CMS MolDx contractor on those Medicare patients tested under the Decipher Prostate Cancer Classifier CTR.

This Adverse Event Report form is provided in order to capture undesirable experiences of a serious nature that occur to a Medicare patient being followed in the Decipher CTR.

Decipher Corp. has agreed to receive these reports for the purpose of reporting to CMS MolDx contractor on your behalf in compliance with the LCD. To protect the confidentiality of protected health information (PHI), all data collected will be de-identified and aggregated for reporting to CMS MolDx contractor. If you have any questions, you may contact Customer Support at 888.792.1601.

Accession #: _____ Date of Last Follow Up: ____/____/_____
MM / DD / YYYY

1. **Decipher Result:** Select

2. **Evidence of Disease progression, if any:**

- ☐ Biochemical Failure
- ☐ Local Recurrence
- ☐ Development of Metastasis
- ☐ Prostate Cancer-Specific Death
- ☐ Non-Prostate Cancer Related Death
- ☐ N/A, No Evidence of Disease Progression
- ☐ Other _____

a. On what date was the adverse event diagnosed? ____/____/_____
MM / DD / YYYY

b. What interventions were performed in response, if any (include date of intervention)?

- ☐ Radiation Therapy, Date: ____/____/_____
- ☐ Androgen Deprivation Therapy, Date: ____/____/_____
- ☐ Secondary Hormonal Manipulation, Date: ____/____/_____
- ☐ Additional Hormonal Manipulation, Date: ____/____/_____
- ☐ Other Systemic Therapy (Sipuleucel, Taxotere), Date: ____/____/_____
- ☐ Other Chemotherapy, Date: ____/____/_____
- ☐ Other: _____

MM / DD / YYYY

To the best of my knowledge, the information above is accurate.

_____ _____ ____/____/_____

HEALTHCARE PROVIDER NAME (PRINT NAME) HEALTHCARE PROVIDER SIGNATURE DATE (MM/DD/YYYY)

NPI #: _____ Healthcare Provider Phone: (____) ____ - _____ Email: _____

PLEASE FILL OUT THE FORM ABOVE AND RETURN THE SIGNED COPY VIA DOCUSIGN, FAX 855.324.2768 OR EMAIL CUSTOMERSUPPORT@DECIPHERBIO.COM

FOR QUESTIONS, CALL CUSTOMER SUPPORT AT 888.792.1601

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