cologuard®
Rx only

Appointment Date:

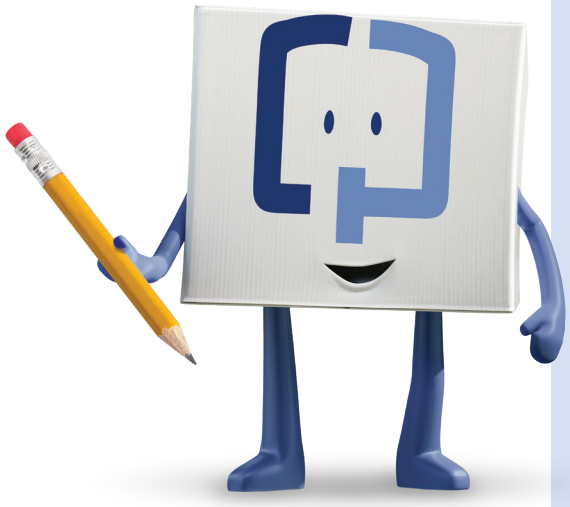
DISCUSSION GUIDE

LET'S *talk.*

If you're 45 years of age or older, you know it's time to talk to your healthcare provider about colon cancer screening. Cologuard® is a noninvasive test for average risk patients that uses the DNA in your stool to detect colorectal cancer. It requires no special preparation, no time off and it's easy-to-use at home!

Print this Discussion Guide and take it to your next to your next healthcare provider appointment.

Include your full medical history when discussing the following questions. Ask if Cologuard is an appropriate screening option for you.



ANSWER *this:*

Have you ever been screened for colon cancer?
___ Yes ___ No

Have you been avoiding screening?
___ Yes ___ No

ASK *this:*

___ What are my risk factors for colon cancer? What are the symptoms?

___ What are my screening options? How do they differ?

___ Is Cologuard right for me?

Healthcare Providers

Ready to order Cologuard? Visit **CologuardTest.com** to download an order form today. To learn more or contact us, call **1-844-870-8870.**

Cologuard is intended to screen adults 45 years of age and older who are at average risk for colorectal cancer by detecting certain DNA markers and blood in the stool. Do not use if you have had adenomas, have inflammatory bowel disease and certain hereditary syndromes, or a personal or family history of colorectal cancer. Cologuard is not a replacement for colonoscopy in high risk patients. Cologuard performance in adults ages 45-49 is estimated based on a large clinical study of patients 50 and older.

The Cologuard test result should be interpreted with caution. A positive test result does not confirm the presence of cancer. Patients with a positive test result should be referred for diagnostic colonoscopy. A negative test result does not confirm the absence of cancer. Patients with a negative test result should discuss with their doctor when they need to be tested again. False positives and false negative results can occur. In a clinical study, 13% of people without cancer received a positive result (false positive) and 8% of people with cancer received a negative result (false negative). Rx only.

EXACT SCIENCES CORPORATION
441 Charmany Drive, Madison, WI 53719
ExactSciences.com | ExactLabs.com | 1-844-870-8870

EXACT SCIENCES

EXACT SCIENCES LABORATORIES

COLOGUARD® ORDER REQUISITION FORM

Stool-based DNA test with hemoglobin immunoassay component

EXACT SCIENCES LABORATORIES, LLC
145 E Badger Rd, Ste 100, Madison, WI 53713
p: 844-870-8870 | ExactLabs.com
NPI: 1629407069 TIN: 463095174

Provider & Order Information

Recommended: type all Provider information.
Editable, printable PDF available at exactlabs.com

PROVIDER INFORMATION

Healthcare Organization Name: _____

Provider Name: _____

NPI #: | | | | | | | | | | |

Location Address: _____

City, State, Zip: _____

Phone Number: _____

Secure Fax Number*: _____

*To receive results for this order, please provide **secure** FAX number only

ORDER INFORMATION

This section is not intended to influence the medical judgment of an ordering provider in determining whether this test is right for any particular patient. The following codes are listed as a convenience. Ordering practitioners should report the diagnosis code(s) that best describes the reason for performing the test.

ICD-10 Code:

○ Z12.11 and Z12.12 (Encounter for screening for malignant neoplasm of colon [Z12.11] and rectum [Z12.12])

☐ Other(s) _____

Certification

I am a licensed healthcare provider authorized to order Cologuard. This test is medically necessary and the patient is eligible to use Cologuard. I will maintain the privacy of test results and related information as required by HIPAA. I authorize Exact Sciences Laboratories to obtain reimbursement for Cologuard and to directly contact and collect additional samples from the patient as appropriate.

_____

Ordering Provider Signature ***Date of Order***

Patient Demographics

Attach a copy of the front & back of primary and/or secondary insurance cards.

Patient ID/MRN: _____

First Name: _____ Last Name: _____

DOB (mm/dd/yyyy): _____ Sex: ○ Male ☐ Female

Phone Number *(required)*: _____
○ Home ○ Mobile ○ Work

Language Preference *(optional)*: _____

Shipping Address: _____

_____

City, State, Zip: _____

Billing Address: _____
☐ *Same as Shipping*

_____

City, State, Zip: _____

PATIENT ETHNICITY AND RACE

The completion of this section is optional.

Is your patient of Hispanic or Latino origin or descent? ○ Yes ☐ No

Please mark one or more to indicate your patient's race:

○ White ☐ Black or African-American ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ American Indian or Alaska Native

Patient Insurance/Billing Information

Only completion of "Policyholder Name" and "Policyholder DOB" is necessary when attaching a copy of the front & back of primary and/or secondary insurance cards.

Does patient wish Exact Sciences to bill their insurance? ○ Yes *(complete below)* ☐ No *(patient will self-pay)*

Policyholder Name: _____ Policyholder DOB: _____ Relationship to patient: ○ Self ☐ Spouse ☐ Other

Primary Insurance Carrier: _____ Type: ○ Private ☐ Medicare ☐ Medicare Advantage ☐ Medicaid ☐ Tricare

Claims Submission Address: _____

Subscriber ID/Policy Number: _____ Group Number: _____ Plan: _____

Prior-Authorization Code *(if available)*: _____

PATIENT AUTHORIZATIONS, ASSIGNMENT OF BENEFITS (AOB) & FINANCIAL RESPONSIBILITIES

I authorize Exact Sciences Laboratories (Exact) to bill my insurance/health plan and furnish them with my Cologuard order information, test results, or other information requested for reimbursement. I assign all rights and benefits under my insurance plans to Exact and authorize Exact to appeal and contest any reimbursement denial, including in any administrative or civil proceedings necessary to pursue reimbursement. I authorize all reimbursements to be paid directly to the laboratory in consideration for services performed. I understand that I am responsible for any amount not paid, including amounts for non-covered services or services determined by my plan to be provided by an out-of-network provider. I further understand that if I am a Medicaid enrollee in a state where Exact is enrolled as a Medicaid provider, Exact will accept as payment in full the amounts paid by the Medicaid program, plus any deductible, coinsurance or copayment which may be required by the Medicaid program to be paid by me.

Patient Signature: _____ Date: _____

Fax completed form to 844-870-8875

For Lab Use Only	
Sample Collected: __/__/____	Sample Received: __/__/____