

POST-TEST TREATMENT - FORM 2

DECIPHER CERTIFICATION AND TRAINING REGISTRY (DECIPHER CTR)

Date: ____/____/____
MM / DD / YYYYPatient'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 MoDx 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 Biosciences has agreed to receive these reports for the purpose of reporting to CMS MoDx 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 MoDx contractor. If you have any questions, you may contact Decipher Customer Service at 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?

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 855.324.2768 OR
EMAIL CS@DECIPHERBIO.COM**

FOR QUESTIONS, CALL CUSTOMER SUPPORT AT 888.792.1601, OPTION 8

