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: ____/____/_______ (MM / DD / YYYY) Physician's Name: ____________________

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 Biosciences 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 Decipher Customer Service at 1.888.792.1601.

Accession #: _________________ Date of Last Follow Up: ____/____/_______ (MM / DD / YYYY)

1. **Decipher Result:**

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: ____/____/_______ (MM / DD / YYYY)
Androgen Deprivation Therapy, Date: ____/____/_______ (MM / DD / YYYY)
Secondary Hormonal Manipulation, Date: ____/____/_______ (MM / DD / YYYY)
Additional Hormonal Manipulation, Date: ____/____/_______ (MM / DD / YYYY)
Other Systemic Therapy (Sipuleucel, Taxotere), Date: ____/____/_______ (MM / DD / YYYY)
Other Chemotherapy, Date: ____/____/_______ (MM / DD / YYYY)
Other: __________________________________

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

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