GRAIL Galleri test attestation form

The Defense Health Agency (DHA) evaluation of US FDA non-approved Laboratory Developed Test (LDT) Demonstration project allows for coverage of specific LDTs when the criteria for coverage have been met. TRICARE beneficiaries are eligible for coverage of the GRAIL Galleri laboratory-developed test once an elevated cancer risk has been established.

Complete this form in its entirety and answer all the questions below. This form can be uploaded along with any supporting clinical documentation and attached to the authorization online.

This is provided as a courtesy only. Providers are not required to use this form; however, failure to provide necessary, clinical information may result in delays, terminations of authorized care or denials for pended claims.

Beneficiary full name: _____ DOB:_____ Sponsor ID: _____

Beneficiary address: _____

City: _____ State: _____ ZIP Code: _____

Provider point of contact: _____

Ordering provider and title: _____

National Provider Identification (NPI): _____ Phone: _____

1. What is the beneficiary's current height and weight? Height: _____ Weight: _____
2. Has the beneficiary had a previous Galleri test within the last year?

   ☐ Yes ☐ No
3. Is the beneficiary a current or previous smoker with a 20-pack per year history?

   ☐ Yes ☐ No
4. Does the beneficiary have a first-or second-degree relative on the same side of the family with one or more of the following conditions:

   ☐ Breast, colon, gastric, endometrial or kidney cancer at or before age 50
   ☐ Triple negative breast cancer (any age)
   ☐ Male breast cancer (any age)
   ☐ Ovarian, pancreatic or sarcoma cancer (any age)
   ☐ Neuroendocrine cancer or tumors (any age)
   ☐ Metastatic prostate cancer (any age)
   ☐ Multiple primary cancers (example bilateral breast cancer)
5. Does the beneficiary have ≥ two first or second degree relatives on same side of the family (any combination is acceptable) with breast or prostate cancer at any age?

   ☐ Yes ☐ No

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6. Is the beneficiary undergoing or has been referred for a clinical evaluation for symptoms suspicious for cancer (e.g., referred to a medical or surgical oncologist, or scheduled for biopsy on the basis of a suspicious imaging abnormality)?

   ☐ Yes ☐ No

7. Does the beneficiary have active cancer requiring intervention?

   ☐ Yes ☐ No

8. Does the beneficiary have a personal history of invasive solid tumor or hematologic malignancy?

   ☐ Yes ☐ No

9. Is the beneficiary currently pregnant?

   ☐ Yes ☐ No ☐ Not applicable

10. Does the beneficiary have a family history of cancer with the results of a germline mutation in a cancer predisposing gene and who have tested negative for that same familial germline mutation?

    ☐ Yes ☐ No

11. Has the beneficiary ever undergone a cancer risk-reducing surgery for hereditary cancer risk (e.g., mastectomy)?

    ☐ Yes ☐ No

12. Does the beneficiary have a known hematologic precursor disease (e.g., Clonal Hematopoiesis of Indeterminate Potential (CHIP), Monoclonal Gammopathy of Undetermined Significance (MGUS), which may result in a cancer signal detected on the Multi-Cancer Early Detection (MCED) test)?

    ☐ Yes ☐ No

13. Is the beneficiary currently taking demethylating or cytotoxic agents for any condition?

    ☐ Yes ☐ No

14. 14. Has the beneficiary received counseling regarding the requested test(s):

    ☐ Yes ☐ No

I attest the information provided on this form is accurate and complete to the best of my knowledge: ☐ Yes ☐ No

Ordering provider signature: _____ Date:_____

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