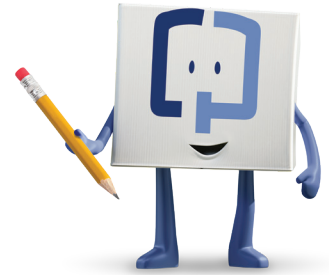


Hi there! Let's talk about Cologuard®

So, you're ready to talk about Cologuard and colon cancer **screening**? Great. Colon cancer screening is an important step in taking care of yourself. Just print and fill out this discussion guide to make the most out of your conversation with your healthcare provider.



Before talking to your healthcare provider

There are **several ways** to get in touch with your healthcare provider so you can screen for colon cancer on time. Schedule an in-office visit, a telemedicine appointment, or send a message through their office portal.

If you make an in-office or telemedicine appointment, note it here and add it to your calendar:

_____ _____
date time

Before speaking to your healthcare provider, **answer** these questions and share your responses with them:

	Yes	No	Not sure	
Are you 45 years or older?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have a personal history of colon cancer, adenomas, or other related cancers?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Have any one of your parents, siblings, or children been diagnosed with colon cancer before age 60? Or have 2 or more of these relatives been diagnosed at any age?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Have you screened before? If so, when?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	mm/yyyy <input style="width: 100px; height: 20px;" type="text"/>
Has your healthcare provider recommended screening and you haven't done it yet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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. Cologuard performance in repeat testing has not been evaluated.

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.

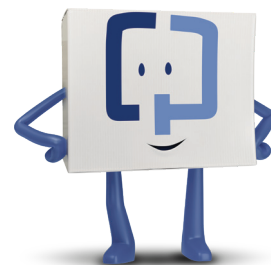
During the discussion

When thinking about your screening options, here are some questions you can ask your **healthcare provider** to help make the best decision:

- ┌ How do I know if I'm at average risk, not high risk, for colon cancer?
- ┌ When am I due to screen or rescreen for colon cancer? Should I screen right away?
- ┌ Is Cologuard right for me?
- ┌ If I use Cologuard, how do I complete the test and how will I learn about the results?

When you're ready, let your healthcare provider know why you would like to **request Cologuard**:

- ┌ I want to **screen** for colon cancer as soon as I'm due
- ┌ I like that Cologuard is **noninvasive**, there's no prep, and you can use it at home
- ┌ I know Cologuard is effective—it finds **92%** of colon cancers, even in early stages



Once you and your healthcare provider have agreed Cologuard is right for you, then it's time to fill out the **order form** that's found at the end of this guide. You can complete it on your own, or your healthcare provider's office can fill it out for you.

Don't forget to ask your healthcare provider for the Cologuard Welcome Guide.

After Cologuard is ordered

Once it's been ordered by your provider, your Cologuard kit will be **delivered** to your doorstep. When it arrives, check the expiration date and use it as soon as possible. Place the kit in your bathroom so it's ready when you are.

Helpful resources:

- ┌ Visit **CologuardTest.com** for more useful information
 - ┌ Download the **Cologuard Welcome Guide** (available in 9 languages) for more info, including understanding results
 - ┌ Read stories from people who have screened with Cologuard
- ┌ Customer Care Specialists are here to help 24/7 at **1-844-870-8870**
- ┌ Scan the code to the right to watch the **How to Use video**, or visit **CologuardTest.com/use**



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

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US.CG.3266-1-June 2020

Provider & Order Information

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

PROVIDER INFORMATION

Healthcare Organization Name: _____

Provider Name: _____

NPI #:

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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

Shipping Address: _____

City, State, Zip: _____

Phone Number (required): _____
 Home Mobile Work

Language Preference (optional): _____

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: ___/___/___