Caris MI Clarity™ Test Request Form

For Project ID Use Only

For fastest order processing, order online at portal.caris.ai
Phone: (888) 979-8669 | Fax: (866) 479-4925 | Email: CustomerSupport@CarisLS.com
Incomplete or missing information may result in delayed testing.

ORDERING PHYSICIAN INFORMATION **Indicates a required field.*

*Name		*NPI
*Physician Email	*Office Contact Name	
*Office/Hospital Name	*Address	
*City	*State	*Zip
*Phone	*Fax	

PATIENT INFORMATION **Indicates a required field.*

*Last Name	*First Name		MI
In-Office Medical Record Number	*DOB	Biological Sex ☐ M ☑ F	Ethnicity
*Address			Apt.
*City		*State	*Zip
Mobile Phone	Email		

TEST SELECTION *Selection required.*

☐ **Caris MI Clarity™**

Caris MI Clarity™ is an AI-powered breast cancer test designed to provide recurrence risk and treatment decision-support information in early-stage breast cancer (HR+/HER2-). The test analyzes digitized hematoxylin and eosin (H&E) whole-slide images together with clinicopathologic variables to generate **early distant recurrence (EDR)** risk (0–5 years) and **late distant recurrence (LDR)** risk (5–15 years). These probabilities are subsequently stratified into categorical risk groups (e.g., low vs. high risk). Results may also include assessment of potential benefit from chemotherapy and/or extended endocrine therapy to support personalized treatment decisions.

☐ **Caris MI Clarity™ – Late Distant Recurrence Only**

Select this option to receive the **late distant recurrence (LDR)** only result. Provides late (5-15 years) distant recurrence-risk assessment and extended endocrine therapy benefit information for eligible patients.

Reporting note: Premenopausal patients are only eligible to receive Early Distant Recurrence (EDR) results.

CLINICAL INFORMATION **Indicates a required field. Include a copy of the most recent progress notes.*

ICD-10 Code(s)	*Date of Original Diagnosis	*Primary Tumor/Specimen Site ☑ Breast	*Tumor Grade ☐ Low ☐ Intermediate ☐ High
*Menopausal Status at Time of Diagnosis ☐ Premenopausal ☐ Postmenopausal	*ER Status ☐ Positive ☐ Negative	*PR Status ☐ Positive ☐ Negative	*HER2 Status ☐ Positive – Ineligible ☑ Negative
*TNM Stage ☐ T1 ☐ T2 ☐ T3 | ☐ N0 ☐ N1 ☐ N2 ☐ N3 | ☐ M0 ☐ M1 – Ineligible		*Surgery Type ☐ Lumpectomy ☐ Mastectomy	*Note: For patients with core needle biopsy only, select the planned surgery type (Lumpectomy or Mastectomy).*

SPECIMEN/PATHOLOGY LOCATION INFORMATION **Indicates a required field. Include a copy of the pathology report.*

*Laterality (Submitted Specimen) ☐ Left ☐ Right	*Tumor Size (mm)	*Specimen ID	*Specimen Collection Date
*Pathology Services/Specimen Storage Location		*Address/Suite	
*City	*State / *Zip	*Phone	*Fax

BILLING INFORMATION *Attach the front and back of PRIMARY and SECONDARY insurance cards.*

☐ Insurance ☐ Self Pay
☐ Direct/Client Bill # _____
☐ HMO/Referral # _____
☐ Other _____

	Insurance Provider	Policy #	Group #	Insured Name	Insured DOB	Relationship to Patient	Prior Authorization #
Primary							
Secondary							

SPECIAL INSTRUCTIONS/ADDITIONAL CC PHYSICIAN CONTACT INFORMATION *Optional*

Special Instructions

Additional Physician Name to be Copied	Facility Name	Additional Physician Email

SPECIMEN REQUIREMENTS

FFPE Block	One (1) tumor-containing formalin fixed paraffin embedded block (FFPE) from **most recent lumpectomy, mastectomy, or core needle biopsy. Tissue area ≥ 4mm²**.
Unstained Slides	One (1) unstained, positively charged, unbaked slide from one single, tumor-containing formalin fixed paraffin embedded block; 4 micron thickness. Note: **Tissue area ≥ 4mm²** is required for Caris MI Clarity™. This test has been validated using the following slides. If submitting slides, please select one: ☐ Avantor VWR Superfrost Plus, Ref# 48311-703 ☐ Epredia Colorfrost Plus Slide, Ref# 9991002 ☐ Epredia Superfrost Plus Gold, Ref# FT4981IGLPLUS-001 ☐ Fisherbrand Superfrost Plus, Ref#1255015 ☐ Matsunami APS, Ref#SUAPS19 ☐ Matsunami CREST, Ref# NTOM1190 ☐ Statlab KT Premium, Ref# KT5+WH-90 ☐ Other: _____ Submission on other slide types will be accepted and tested; however, the likelihood of success may be reduced.

PHYSICIAN ATTESTATION OF MEDICAL NECESSITY **Indicates a required field.*

This requisition constitutes an order for Caris MI Clarity™ laboratory testing from Caris MPI, Inc. (Caris) I certify (a) the services are medically necessary and will assist me in treating my patient, (b) the patient has sufficient performance status to receive additional treatment, (c) I will make available patient medical records documenting the foregoing, and (d) I supplied information to the patient regarding this testing, explained the purpose of this testing to the patient, and obtained informed consent for (i) such testing, (ii) any analysis and reports related to such testing, (iii) Caris to retain testing results, samples and related information and analysis, (iv) Caris' use or disclosure (including to third parties) of de-identified information generated from such testing for general research and other purposes, (v) Caris' disclosure of testing results and information to third-party payers in connection with such testing, and (vi) for Caris to contact the patient regarding the testing.

***Authorized Provider Signature**

***Provider Name (Print)**	***Date**

Caris MPI, Inc. d/b/a Caris Life Sciences ©2026 Caris MPI, Inc. All rights reserved. MAT-MC-000001 11 NOV 2026