## Summary of Results

PATIENT NAME: **Last Name, First Name** DOB: **10-Jan-1961**

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| | | | | | |
|---|---|---|---|---|---|
| **GENDER:** | Female | **ORDERED BY:** | Dr. Doe, John | **REQUISITION #:** | 1234567 |
| **SPECIMEN ID:** | MRN 123456 | **ACCOUNT:** | John Doe Hospital | **SPECIMEN TYPE:** | FFPE, Core |
| **PATIENT/MRN:** | 945839302 | | 1234 Main St. | **SPECIMEN SOURCE:** | Left Breast |
| **CUSTOMER REF:** | 123456789 | | Irvine CA 92618 USA | **COLLECTED DATE:** | 18-Feb-2017 |
| | | | | **RECEIVED DATE:** | 19-Feb-2017 |
| | | | | **REPORTED DATE:** | 21-Feb-2017 |

## Summary of Results: LOW RISK LUMINAL-TYPE (A)

| MammaPrint 70-Gene Risk of Recurrence | BluePrint 80-Gene Molecular Subtype |
|---|---|
| **LOW RISK** | **LUMINAL-TYPE** |

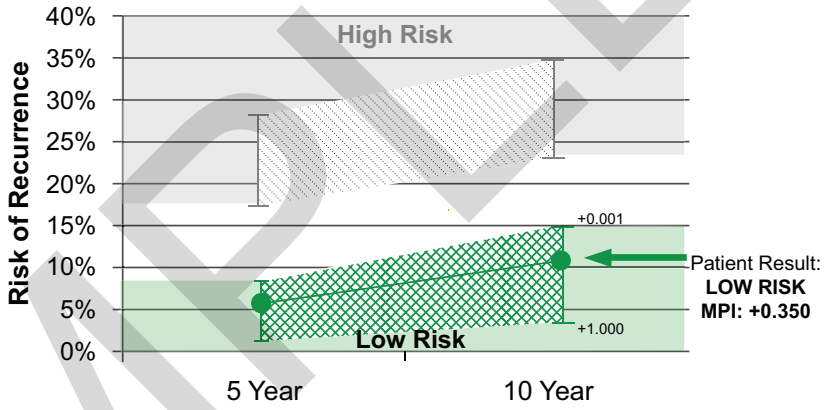
**Patient's MammaPrint Result: LOW RISK**

Average 10-year Risk of Recurrence Untreated[1]: **10%**

Patient's MammaPrint Index: (MPI) **+0.350**

MPI Low Risk Reference Range: +0.001 → +1.000

**Predicted Risk of Recurrence WITHOUT ADJUVANT SYSTEMIC TREATMENT After Diagnosis**




## Expected Values§

### Predicted Prognosis for MammaPrint LOW RISK[2]

Observed Population: ER positive, HER2 negative, Lymph Node negative patients (ER+/HER2-/LN0) from the MINDACT trial

**97.8%***

97.8% of LOW RISK MammaPrint patients who were treated with hormonal therapy alone (Tamoxifen/Aromatase Inhibitor) are living without distant recurrence of breast cancer at 5-years (DMFI*).

***Distant Metastasis Free Interval (DMFI):**
Freedom from distant recurrence or deaths due to breast cancer at 5-years
***Treatment:** Hormonal Therapy Alone

### Predicted Benefit of Treatment at 5-Years[2]


***MammaPrint LOW RISK: No Potential Significant Chemotherapy Benefit***

Note: This information is provided for general information purposes. It is not part of any official diagnostic report. Please refer to individual MammaPrint and BluePrint reports for comments, assay information, disclaimer and references.

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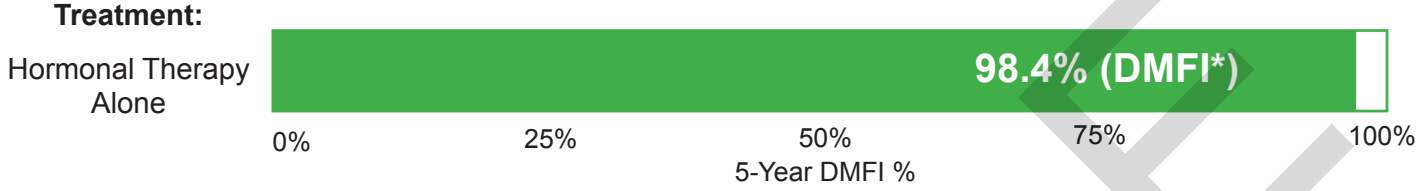
## Predicted Benefit of Treatment Based on Clinical and Genomic Risk at 5-Years[2]

The integration of clinical risk assessment with MammaPrint results can help refine an individual's prognosis to help better guide the most appropriate treatment strategy. The following outcomes; % of patients without distant recurrence or death at 5-years (DMFI) were observed in the MINDACT trial. (Clinical risk can be determined by utilizing the clinical risk algorithm on Page 3.)

### Clinical LOW RISK / MammaPrint LOW RISK

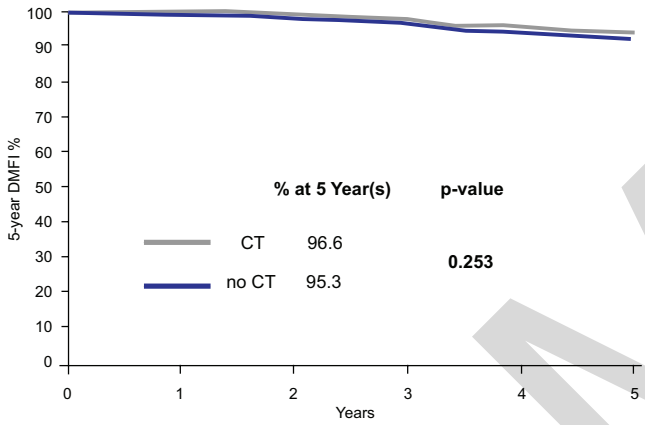
Observed Population: ER positive, HER2 negative, Lymph Node negative patients (ER+/HER2-/LN0)

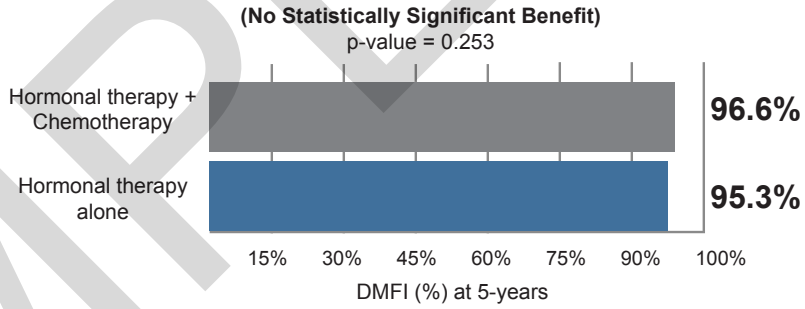
**Treatment:**




### Clinical HIGH RISK / MammaPrint LOW RISK

Observed Population: Clinically high risk patients including Lymph Node positive (LN+ 1-3)

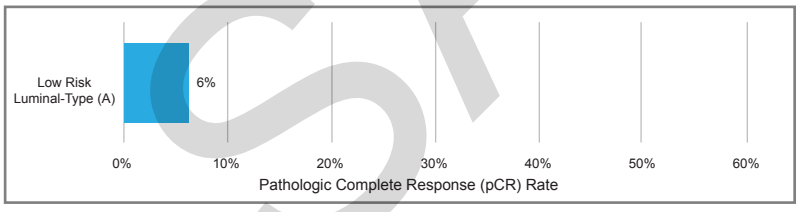



***Clinical HIGH RISK / MammaPrint LOW RISK: No Significant Chemotherapy Benefit***

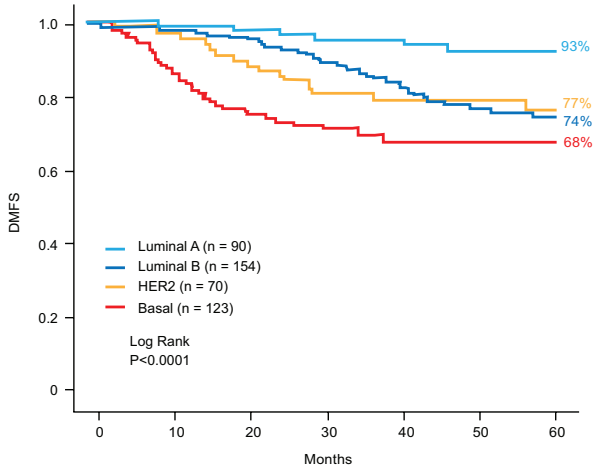
## Neoadjuvant Response to Therapy According to Molecular Subtyping[3]

### Low Risk Luminal-Type (A) Neoadjuvant Chemosensitivity




| Subtype Results | Chemosensitivity Relevance |
|---|---|
| Low Risk Luminal-Type (A) | • Low likelihood of pCR<br>• No expected benefit from chemotherapy<br>• Endocrine therapy further reduces risk |

### Distant Metastasis-Free Survival (DMFS) by Molecular Subtype

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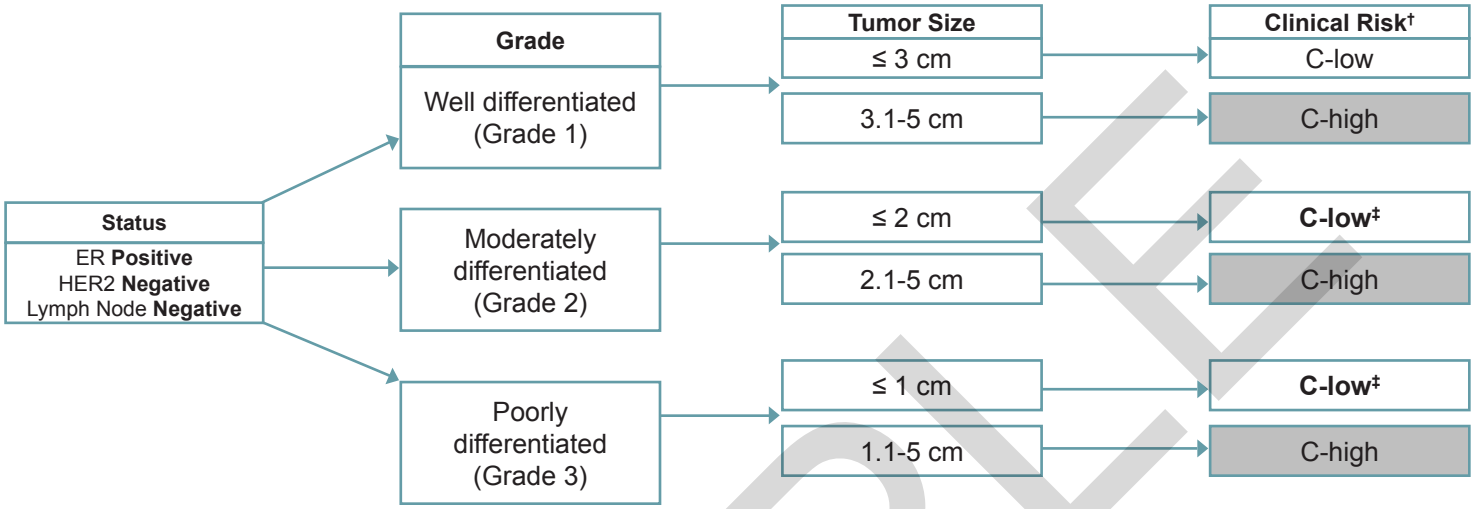
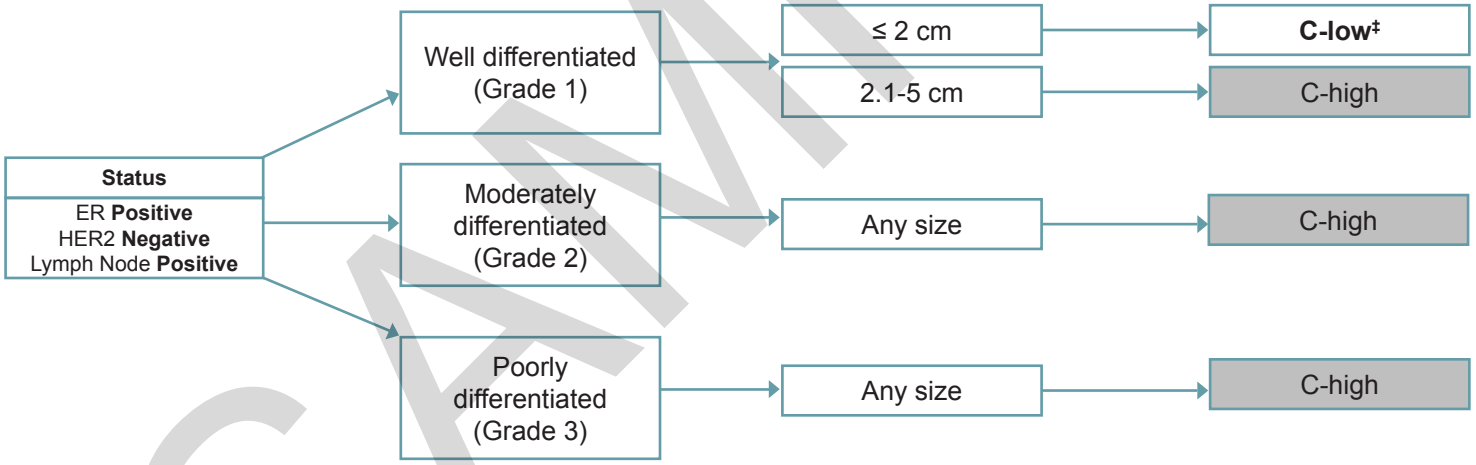
## Clinical Risk Assessment in the MINDACT Trial[2]

### Hormone Receptor Positive, HER2 Negative, Lymph Node Negative (HR+, HER2-, LN0):




### Hormone Receptor Positive, HER2 Negative, Lymph Node Positive (HR+, HER2-, LN+ 1-3):




† Clinical Low Risk was defined using Adjuvant!Online (modified version 8.0, including HER2) as greater than 88% breast cancer specific survival capability at 10-years, without systemic therapy to account for the average absolute benefit of adjuvant endocrine therapy for ER+ patients.

‡ Comprehensive Consensus Guidelines may differ and categorize a patient with these clinical factors as high risk.

§**Expected Values**: Expected values for prognosis are based on a patient population average as observed in the MINDACT trial[2]

**References:**
1. Buyse M, et al. J NatlCancer Inst. 2006 Sep 6;98(17):1183-92.
2. Cardoso F, et al. N Engl J Med. 2016 Aug 25;375(8):717-29.
3. Glück S, et al. Breast Cancer Res Treat. 2013 Jun;139(3):759-67.