# Behind the Seizure® Program Eligibility/Clinical Criteria

FM145-9

This form is required to complete an online submission for the Behind The Seizure® program, a complimentary Invitae Epilepsy Panel U.S. testing program brought to you by BioMarin Pharmaceutical Inc., Stoke Therapeutics, Xenon Pharmaceuticals, and Invitae Corporation. Please confirm that the patient meets the eligibility requirements for the program. To submit orders for genetic testing outside of this program, please order through Invitae's online portal or use a standard requisition form, accessible at www.invitae.com/order-forms.

## PROGRAM ELIGIBILITY:

Any child up to 60 months old who has had an unprovoked seizure.

| Patient name | Date of birth (MM/DD/YYYY) |
|---|---|
| | |

## BEHIND THE SEIZURE PROGRAM ELIGIBILITY/CLINICAL INFORMATION

**Required patient information:**

**Eligibility information (required).**

Current age of child (in months): _____ months
*(For eligibility the patient must be <60 months old)*

Age of child (in months) at onset of unprovoked seizures: _____ months

**Required medical history:**

| Generalized seizures (check all that apply) | Y | N | Unknown |
|---|---|---|---|
| Febrile seizures | ☐ | ☐ | ☐ |
| Generalized seizures | ☐ | ☐ | ☐ |
| Focal seizures | ☐ | ☐ | ☐ |
| Other | ☐ | ☐ | ☐ |
| **Family history of epilepsy** | ☐ | ☐ | ☐ |

**Required medical history:**

| Developmental delays | Y | N | Unknown |
|---|---|---|---|
| Language development delay | ☐ | ☐ | ☐ |
| Motor difficulty | ☐ | ☐ | ☐ |
| Developmental delay preceded seizure onset | ☐ | ☐ | ☐ |
| Other: | ☐ | ☐ | ☐ |

| Previous test results if available (please append any relevant results at the end of this form) | Y | N | Unknown |
|---|---|---|---|
| Genetic (single gene, panel, exome, or CMA) | ☐ | ☐ | ☐ |
| Biochemical (including metabolic) | ☐ | ☐ | ☐ |
| Abnormal EEG | ☐ | ☐ | ☐ |
| Abnormal MRI | ☐ | ☐ | ☐ |
| Previous CLN2 (TPP1) enzyme testing | ☐ | ☐ | ☐ |

**Suspicion of genetic basis of epilepsy**

Clinical diagnosis or suspicion of a specific syndrome or disorder. Please specify:

_____

_____

*Y = test performed and/or medical history taken AND material finding reported; N = test performed and/or medical history taken AND no material finding; Unknown = not in medical record and/or test not performed*

By signing this form, the medical professional acknowledges that the individual/family member authorized to make decisions for the individual (collectively, the "Patient") has been supplied information regarding and consented to undergo genetic testing, substantially as set forth in Invitae's Informed Consent for Genetic Testing (www.invitae.com/patient-consent) and in connection with the Behind the Seizure program, and has been informed that Invitae may notify them of clinical updates related to genetic test results (in consultation with the ordering medical professional as indicated). The medical professional warrants that he/she will not seek reimbursement for this no-cost test from any third party, including but not limited to federal healthcare programs. The medical professional also hereby acknowledges that organization and clinician contact information provided in the order may be shared with third parties, including BioMarin Pharmaceutical Inc., Stoke Therapeutics, and Xenon Pharmaceuticals, that may contact the medical professional directly in connection with the Behind the Seizure program, and that they have made the Patient aware that third parties, including BioMarin Pharmaceutical Inc., Stoke Therapeutics, and Xenon Pharmaceuticals, may contact their medical professional regarding de-identified information gathered through the program. In addition to the above, I attest that I am the ordering physician, or I am authorized by the ordering physician to order this test, or I am authorized under applicable state law to order this test.

| Medical professional signature | Date |
|---|---|
| | |