INVITAE AlnylamAct®

ORDER ID
For Invitae internal use only

Requisition Form
ALNYLAM ACT® (hATTR AMYLOIDOSIS) TRF921-8

This requisition form can be used to submit an order for the **Alnylam Act®**, a sponsored testing program for genetic disorders brought to you by **Alnylam Pharmaceuticals** and **Invitae Corporation**.

INSTRUCTIONS: Review the ordering options and then complete all sections of this form. Your ordering option will be indicated in the test selection section.

ORDERING OPTIONS

1. ALNYLAM ACT® (hATTR AMYLOIDOSIS) PROGRAM

For individuals that meet the eligibility criteria below and wish to receive the program specific genetic testing panels.

REQUIRED: You must select below the appropriate eligibility criteria for this patient.

Patient must be age 18 or older AND have a family history or suspected diagnosis of hATTR amyloidosis with one or more of the following signs and symptoms. Please check all that apply:

- ◯ Family history of hATTR amyloidosis
- ◯ Sensory and/or motor neuropathy (e.g., neuropathic pain, alternation sensation [sensitivity to pain and temperature], numbness and tingling, muscle weakness, impaired balance, difficulty walking)
- ◯ Autonomic dysfunction (e.g., nausea and vomiting, changes in GI motility [diarrhea, constipation, gastroparesis, early satiety], orthostatic hypotension [fainting and dizziness upon standing], sexual dysfunction, bladder dysfunction)
- ◯ Bilateral carpal tunnel syndrome
- ◯ Spinal stenosis or spinal radiculopathy
- ◯ Heart disease (e.g., shortness of breath, edema, palpitations, arrhythmias, conduction abnormalities, heart failure, abnormal cardiac imaging [echo, MRI, or technetium])
- ◯ Renal abnormalities (e.g., renal insufficiency and/or proteinuria)
- ◯ Ocular changes (e.g., blurred vision, blindness, dry eyes, glaucoma, visual field abnormalities, retinal detachment)
- ◯ Biopsy positive for amyloid
- ◯ Other (must be completed if checked): _____

_____

2. GENE-SPECIFIC FAMILY FOLLOW-UP TESTING

For relatives of program participants who received a Pathogenic/Likely Pathogenic result or approved VUS who want to receive gene specific family follow-up testing at no additional cost. Relatives do not need to meet the eligibility criteria listed above, but must be age 18 or older. Learn more at www.invitae.com/family.

PATIENT INFORMATION

First name	MI	Last name
Date of birth (MM/DD/YYYY)	Biological sex ◯ M ◯ F	MRN (medical record number)

Ancestry ◯ Asian ◯ Black/African American ◯ White/Caucasian ◯ Ashkenazi Jewish ◯ Hispanic ◯ Native American ◯ Pacific Islander ◯ French Canadian ◯ Sephardic Jewish ◯ Mediterranean ◯ Other: _____

Phone	Email address (report access after clinician releases)	
Address		City
State/Prov	ZIP/Postal code	Country

Ship a saliva kit to this patient (to submit, fax this form to Client Services at 415-276-4164)
- ◯ Ship kit to address above
- ◯ Ship kit to alternate address: _____

SPECIMEN INFORMATION

Specimen type: Blood (3-mL purple EDTA) -OR- Saliva (Oragene™) -OR- Assisted Saliva -OR- DNA source: _____

We are unable to accept blood/saliva from patients with:
- *Allogeneic bone marrow transplants*
- *Blood transfusion <2 weeks prior to specimen collection*

Specimen collection date (MM/DD/YYYY): *If not provided, the day before specimen receipt will be used*

Special cases: ◯ History of/current hematologic malignancy in patient

INVITAE PARTNER CODE

TTR

CLINICIAN INFORMATION

Organization name		
Phone	Fax	
Address	City	
State/Prov	ZIP/Postal code	Country

Primary clinical contact name (if different from ordering provider)	NPI
Primary clinical contact email address (for report access)	

Ordering provider (select one ordering provider by marking the checkbox before the name)

	Name	NPI	Email address (for report access)
◯			
◯			
◯			
◯			
◯			
◯			

Additional clinical or laboratory contacts (optional, to share access to order online)

◯ **Share this order with the primary clinical contact's default clinical team, manage at invitae.com**

Name	Email address (for report access)
Name	Email address (for report access)

CLINICAL HISTORY

FAMILY HISTORY

Is there a family history of disease for which the patient is being tested? ◯ Yes ◯ No If yes, describe below and attach pedigree and/or clinical notes.

Relative's relationship to this patient	Maternal or paternal	Diagnosed condition	Age at diagnosis	Relative's relationship to this patient	Maternal or paternal	Diagnosed condition	Age at diagnosis

PERSONAL HISTORY

Is/was this patient affected or symptomatic?† ◯ Yes ◯ No

Provide details in the required clinical history questions (if applicable).

† Symptomatic means this patient has features or signs known or suspected to be related to the genetic testing being ordered and could include findings on physical examination, laboratory tests, or imaging.

OPTIONAL - REQUESTED VARIANTS FOR THIS PATIENT'S REPORT, IF KNOWN

To have the presence or absence of specific variants commented on in this patient's report, provide the details below. For gene-specific family follow-up see ***Note*** *under Test Selection.*

Was the proband (individual with variant) tested at Invitae? ◯ Yes, Invitae Order ID: RQ# _____ ◯ No: Attach copy of lab results (*required*)

Variant(s) *(e.g. GENE c.2200A>T (p.Thr734Ser) NM_00012345) If left blank, all variants identified in the proband will be commented on.*		**This patient's relationship to proband:**
		◯ Parent ◯ Sibling ◯ Grandchild
		◯ Child ◯ Self ◯ Other: _____

TEST SELECTION – Select option 1 or 2 below:

◯ 1. ALNYLAM ACT® (hATTR AMYLOIDOSIS) PROGRAM – Indicate test(s) to be performed below:

Test code	Test name	# of genes	Gene list
◯ 02251	Invitae Cardiomyopathy Comprehensive Panel	50	ABCC9, ACTC1, ACTN2, AGL, BAG3, CACNA1C, CAV3, CRYAB, CSRP3, DES, DMD, DOLK, DSC2, DSG2, DSP, EMD, EYA4, FHL1, FKRP, FKTN, FLNC, GAA, GLA, HCN4, JUP, LAMP2, LMNA, MYBPC3, MYH7, MYL2, MYL3, PKP2, PLN, PRKAG2, RAF1, RBM20, RYR2, SCN5A, SGCD, SLC22A5, TAZ, TCAP, TMEM43, TNNC1, TNNI3, TNNT2, TPM1, TTN, TTR, VCL
◯ 03200	Invitae Comprehensive Neuropathies Panel	72	AARS, AIFM1, ATL1, ATL3, ATP7A, BICD2, BSCL2, CHCHD10, DCTN1, DNAJB2, DNM2, DNMT1, DST, DYNC1H1, EGR2, FAM134B, FBXO38, FGD4, FIG4, GAN, GARS, GDAP1, GJB1, GNB4, HARS, HINT1, HSPB1, HSPB8, IGHMBP2, IKBKAP, INF2, KIF1A, LITAF, LMNA, LRSAM1, MED25, MFN2, MORC2, MPZ, MTMR2, NDRG1, NEFL, NGF, NTRK1, PDK3, PLEKHG5, PMP22, PRPS1, PRX, RAB7A, REEP1, SBF2, SCN11A, SCN9A, SH3TC2, SIGMAR1, SLC25A46, SLC52A2, SLC52A3, SLC5A7, SPG11, SPTLC1, SPTLC2, TFG, TRIM2, TRPV4, TTR, UBA1, VAPB, VRK1, WNK1, YARS
◯ 02265	Invitae Transthyretin Amyloidosis Test	1	TTR

◯ 2. GENE-SPECIFIC FAMILY FOLLOW-UP TESTING *For relatives of a program participant ('proband') who received a Pathogenic/Likely Pathogenic result or approved VUS.*

Proband's Invitae Order ID: RQ# _____	**This patient's relationship to proband:** ◯ Parent ◯ Sibling ◯ Grandchild ◯ Child ◯ Other: _____	**Gene(s) to be tested in this patient:**

NOTE*: The presence or absence of all variants identified in the proband for the gene(s) ordered for gene-specific family follow-up will be commented on in this patient's report unless a limited selection is specified in the* ***Requested Variants*** *section above. Invitae will report any Pathogenic/Likely Pathogenic variants found in this patient for the gene(s) ordered.*

Invitae continually updates its panels based on the most recent evidence. If an order is placed using an outdated test requisition form, Invitae reserves the right to upgrade ordered tests to their current versions. Test IDs containing add-on codes will include the original panel as well as the add-on.

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/forms) and in connection with the Alnylam Act® program, the Patient 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) and has been informed that de-identified Patient data may be used and shared with third parties, including Alnylam Pharmaceuticals, Inc. ("Alnylam"), for research and commercial purposes and, in the U.S., to contact their medical professional. For orders originating in Canada, the Patient has been informed that their personal information and specimen will be transferred to and processed in the U.S. and that de-identified Patient data may be used and shared for research and commercial purposes in the U.S. The medical professional warrants that he/she will not seek reimbursement for this sponsored test from any third party, including but not limited to U.S. 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 Alnylam, that may contact the medical professional directly in connection with the Alnylam Act® program, or Alnylam products. The medical professional understands that the use of this sponsored test is not intended to be, nor should it be construed as, either express or implied, an obligation or inducement for the medical professional to recommend, purchase, order, prescribe, promote, administer or otherwise support any Alnylam product or any other Invitae product or service. I attest that I am authorized under applicable state law to order this test.

Medical professional signature (required)	**Date (MM/DD/YYYY)**