Alnylam Act™ (hATTR Amyloidosis) Program Symptom Checklist

FM148-5

Patients 18 years or older with a suspected diagnosis or a confirmed family history of hereditary ATTR (hATTR) amyloidosis are invited to take part in the Alnylam Act™ program, a no-charge U.S. genetic testing program brought to you by Alnylam Pharmaceuticals and Invitae Corporation.

Please fill out, print, and sign this checklist and include it when sending in the specimen. Additional information about the ordering process can be found at www.invitae.com/alnylam-act-hattr-amyloidosis.

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.

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

Patient must be 18 years or older

ALNYLAM ACT (hATTR AMYLOIDOSIS) SYMPTOM CHECKLIST

Please check all that apply:

- ☐ Family history of hATTR amyloidosis
- ☐ Sensory and motor (e.g., neuropathic pain, alternate 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], erectile dysfunction, bladder dysfunction)
- ☐ Heart disease (e.g., shortness of breath, edema, palpitations, and arrhythmias)
- ☐ Carpal tunnel syndrome
- ☐ Generalized fatigue
- ☐ Unintentional weight loss
- ☐ Ocular changes (e.g., blurred vision, blindness)
- ☐ Other: _____

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 Alnylam Act™ program, 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), has been informed that de-identified Patient data may be used and shared for research purposes, and for orders originating in Canada, has been informed that Patient's 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 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 Pharmaceuticals, that may contact you directly in connection with the Alnylam Act 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 law to order this test.

Medical professional signature	Date

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