Alnylam Act™ (hATTR Amyloidosis) Program Eligibility Criteria

FM148-6

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 Alnylam Act™, a sponsored genetic testing program brought to you by Alnylam Pharmaceuticals and Invitae Corporation.

The patient must meet the eligibility criteria below to qualify for the program. Please fill out, print, and sign this form 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)

ALNYLAM ACT (hATTR AMYLOIDOSIS) ELIGIBILITY CRITERIA

☐ 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)

☐ Heart disease (e.g., shortness of breath, edema, palpitations, arrhythmias, conduction abnormalities, heart failure, abnormal cardiac imaging [echo, MRI, or technetium])

☐ Bilateral carpal tunnel syndrome

☐ Spinal stenosis or spinal radiculopathy

☐ 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):

_____

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, 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 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 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. 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**