INVITAE

SHIPPING INSTRUCTIONS
Please ship specimen overnight in insulated containers:
Attn: Invitae Client Services, 1400 16th Street
San Francisco, CA 94103, USA

ORDER ID
For Invitae internal use only

Requisition Form
UNCOVERING PERIODIC PARALYSIS FAMILY VARIANT TESTING TRF925-2

When a patient receives a pathogenic or likely pathogenic result through the Uncovering Periodic Paralysis program, his or her first degree family members (mother, father, siblings [full and half], and children) are eligible for no-cost family variant testing. Orders must be placed within 90 days of the original patient's test report date. Uncovering Periodic Paralysis is a complimentary Invitae Periodic Paralysis Panel U.S. testing program brought to you by Strongbridge Biopharma™ and Invitae Corporation. 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 INFORMATION

First name | MI | Last name

Date of birth (MM/DD/YYYY) | 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

Address | City

State | ZIP code | Country

SPECIMEN INFORMATION

Label each tube with the patient's full name, date of birth, and specimen collection date.
A requisition form MUST accompany each specimen. www.invitae.com/specimen-requirements

Specimen type: ◯ Blood ◯ Saliva ◯ Assisted saliva ◯ DNA - source:

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

Collection date (MM/DD/YYYY) *If not provided, date will be 1 day prior to our receipt of specimen. For DNA, provide date retrieved from archive.*

Special cases : ◯ History of/current hematologic malignancy ◯ Resubmission

TEST INFORMATION

Invitae's family variant testing programs involves full analysis of the gene in which the original family member's variant was identified. For more information, visit www.invitae.com/family-testing.

Please attach the proband's clinical report or provide Invitae RQ#

INVITAE PROBAND RQ#	RELATIONSHIP TO PROBAND	GENE(S)	VARIANT(S)

PRACTICE INFORMATION

Practice name and address

Institution/practice name

Phone | Fax

Address | City

State | ZIP code | Country

Primary clinical contact

Name | Role/title

Phone | NPI

Email address (for report access)

Ordering physician

◯ **Same as primary clinical contact**

Name | NPI

Email address (for report access)

Additional clinical or laboratory contact (optional)

Name | Email address (for report access)

INVITAE PARTNER CODE UPP

UNCOVERING PERIODIC PARALYSIS PROGRAM CLINICAL INFORMATION

Required patient information:

Has the family member being tested experienced:

Episodic muscle weakness/paralysis attacks **or** episodic pain after attacks (more than one occurrence) ☐ Yes ☐ No

Episodes are provoked by at least one of the common triggers for hyperkalemic or hypokalemic primary periodic paralysis ☐ Yes ☐ No
(see **www.invitae.com/UncoveringPeriodicParalysis** for more information)

Age of onset for signs/symptoms (if applicable): _____

Family history of periodic paralysis: ■ Yes

Has the patient previously been diagnosed with periodic paralysis through another diagnostic test?
☐ Yes ☐ No

If "Yes," through which diagnostic test?
- ☐ Nerve connection/electromyogram (EMG)
- ☐ Electrocardiogram (EKG)
- ☐ Documented serum potassium (K+) changes during an attack
- ☐ Long exercise test (CMAP)
- ☐ Response to medication trial
- ☐ Other, please specify: _____

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 Uncovering Periodic Paralysis 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 practice information set forth above may be shared with third parties, including Strongbridge Biopharma, that may contact the medical professional directly in connection with the Uncovering Periodic Paralysis program, and that they have made the Patient aware that third parties including Strongbridge Biopharma 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**