

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 <input type="radio"/> M <input type="radio"/> F	MRN (medical record number)
Ancestry <input type="radio"/> Asian <input type="radio"/> Black/African American <input type="radio"/> White/Caucasian <input type="radio"/> Ashkenazi Jewish <input type="radio"/> Hispanic <input type="radio"/> Native American <input type="radio"/> Pacific Islander <input type="radio"/> Other:		
Phone	Email address	
Address		City
State	ZIP code	Country

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		
<input type="radio"/> Same as primary clinical contact		
Name	NPI	
Email address (for report access)		
Additional clinical or laboratory contact (optional)		
Name	Email address (for report access)	

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: <input type="radio"/> Blood <input type="radio"/> Saliva <input type="radio"/> Assisted saliva <input type="radio"/> 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)	Special cases <input type="radio"/> History of/current hematologic malignancy <input type="radio"/> 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 PROBRAND RQ#	RELATIONSHIP TO PROBAND	GENE(S)	VARIANT(S)

INVITAE PARTNER CODE	UPP
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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 conduction/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
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