INVITAE

Alnylam Act® (AHP) Program Eligibility Criteria

FM152-4

Patients 16 years or older with a suspected diagnosis or a confirmed family history of hereditary acute hepatic porphyria 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 checklist and include it when sending in the specimen. Additional information about the ordering process can be found at www.invitae.com/alnylam-act-ahp.

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 first name	Patient MI	Patient last name	Date of birth (MM/DD/YYYY)

Patient must be 16 years old or older

ALNYLAM ACT (AHP) ELIGIBILITY CRITERIA

Please confirm that patient meets the eligibility criteria below:

Criteria from **at least ONE of the sections below**:

☐ Patient is 16 years or older, with elevated (greater than the upper limit of normal) urinary porphobilinogen (PBG) or aminolevulinic acid (ALA) levels

OR

☐ Patient is 16 years or older with unexplained recurrent (more than one), prolonged (>24 hours) episodes of severe, diffuse (poorly localized) abdominal pain

AND at least TWO of the following:

☐ Red to brownish urine

☐ Known or suspected family history of an acute hepatic porphyria

☐ Blistering skin lesions on sun-exposed areas

☐ Peripheral nervous system manifestations occurring around the time of abdominal pain (i.e., motor neuropathy [paresis], sensory neuropathy [numbness, tingling, limb pain])

☐ Central nervous system manifestations occurring around the time of abdominal pain (i.e., confusion, anxiety, seizures, hallucinations)

☐ Autonomic nervous system manifestations occurring around the time of abdominal pain (i.e., hyponatremia [Na < LLN], tachycardia, hypertension, nausea and vomiting, constipation)

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). 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. 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 (required)	**Date**