INVITAE

ORDER ONLINE at www.invitae.com/signin.

ORDER ID
For Invitae internal use only

Requisition Form
PORPHYRIAS TRF929-1

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 ◯ Other:

Email address (for report access after release by medical professional)

Phone | Is this patient deceased? ◯ Yes ◯ No Deceased date:

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:

DNA must be extracted in a CLIA or other suitably certified laboratory

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
◯ History of/current hematologic malignancy
◯ Resubmission

REASON FOR TESTING

Primary indication:

ICD-10 codes

Previous results

Testing for a personal history of disease? ◯ **Yes** ◯ **No** If yes, describe below.
Age at diagnosis: _____

ORGANIZATION INFORMATION

Organization name and address

Organization 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)

Letter of Medical Necessity (LMN)

◯ I have attached an LMN and/or other documentation for insurance billing purposes.

◯ I agree to allow Invitae to transfer the information from this requisition to an LMN and/or other documentation using the ordering physician's name as the signature for insurance billing.

Family history? ◯ **Yes** ◯ **No** If yes, describe in detail below or attach pedigree. If there is a known familial variant, indicate here.

◯ INSURANCE BILLING (U.S. ONLY)

◯ **I have attached a copy of the patient's card**

Insurance company name | Member ID#

Patient relation to policy holder: ◯ Self ◯ Child ◯ Spouse ◯ Other

Policy holder name | Prior-authorization #

◯ PATIENT PAY BILLING

Invitae will send an electronic invoice to the patient email listed above

◯ INSTITUTIONAL BILLING

◯ **Send invoice to organization address above**

Billing contact name | Phone | Fax

Billing email address

Billing address | City

State | ZIP code | Country

◯ OTHER BILLING

Invitae partner code:

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), 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 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. The Patient has further been informed and hereby authorizes Invitae Corporation ("Invitae") and its designees to release information concerning testing to their insurer in order to process and/or appeal claims on behalf of the Patient. For amounts received directly, the Patient agrees to remit payment to Invitae for testing services rendered. I acknowledge that I offered pre-test Genetic Counseling to the Patient, if required by their insurer. 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**

HEADQUARTERS & LABORATORY | 1400 16th Street, San Francisco, CA 94103 | www.invitae.com | IN THE US | clientservices@invitae.com | p: 800-436-3037 | f: 415-276-4164
OUTSIDE THE US | globalsupport@invitae.com or visit www.invitae.com/contact |

ORDER INSTRUCTIONS

Select a pre-curated test or customize your own test for each patient. Invitae's pricing is per clinical area for initial order and re-requisition. At this time, the genes within the Invitae Acute Hepatic Porphyrias panel comprise a single clinical area. If your order contains tests from multiple clinical areas, you will need to send in two sample tubes and your order will represent two billable events. Your test results will be delivered as two reports. Please contact Client Services with any questions. For Invitae's full test menu, please visit **www.invitae.com**.

FAMILY VARIANT TESTING

Invitae offers Family Variant Testing at no additional charge within 90 days for the genes in which the original family member's variant was identified. In such cases, please use the Family Variant Testing/VUS Resolution requisition form (TRF920), available at **www.invitae.com/forms**.

ASSAY

Invitae is a CAP-accredited and CLIA-certified clinical diagnostic laboratory performing full-gene sequencing and deletion/duplication analysis using next-generation sequencing technology (NGS). Search for details on the analysis of any gene in our test catalog at **www.invitae.com/physician/search**.

To request a complimentary specimen collection kit visit **www.invitae.com/request-a-kit**

SHIPPING INSTRUCTIONS

Please ship specimen overnight in insulated containers:

Attn: Invitae Client Services
1400 16th Street
San Francisco, CA 94103
USA

Invitae continually updates its panels based on the most recent evidence. Please note that if an order is placed using an older version of this form, Invitae reserves the right to upgrade any ordered panel(s) to the current version(s). To avoid confusion, please consider placing your order using our online test catalog.

CLINICAL AREA: PORPHYRIAS

Test code	Test name	# gene(s)	Gene list
○ 06226	Invitae Acute Hepatic Porphyrias Panel	4	ALAD, CPOX, HMBS, PPOX

PORPHYRIAS INDIVIDUAL GENES

○ ALAD	○ CPOX	○ HMBS	○ PPOX

