INVITAE

SMA Identified

ORDER ID For Invitae internal use only	**Requisition Form** **SMA IDENTIFIED TRF934-2**

This requisition form can be used to submit a specimen for the SMA Identified Program, a no-charge US testing program brought to you by Biogen and Invitae. All US patients* with a suspected or clinical diagnosis of spinal muscular atrophy (SMA) can take part in the SMA Identified Program. 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.

The SMA Identified Program facilitates access to genetic testing to help accelerate or confirm the diagnosis of SMA. While Biogen provides financial support for this program, tests and services are performed by an independent third party, Invitae. Healthcare providers must confirm that patients meet certain criteria to use the program. Biogen receives de-identified patient data from this program, but at no time does Biogen receive patient identifiable information. Biogen receives contact information for healthcare providers who use this program. Genetic testing is available in the U.S. and Puerto Rico only. Healthcare providers who use this program have no obligation to recommend, purchase, order, prescribe, promote, administer, use or support any Biogen product.

***It is a requirement for a qualified, US-based (inclusive of US and Puerto Rico) healthcare provider to submit the request.**

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:

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) *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

REASON FOR TESTING

Previous results *(if applicable and not included in clinical criteria below)*

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)

INVITAE PARTNER CODE SMA

FAMILY VARIANT TESTING

When a patient receives a pathogenic or likely pathogenic result through the SMA Identified Program, his or her first-degree family members (mother, father, siblings [full and half], and children) are eligible for no-charge family variant testing.

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

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

SMA IDENTIFIED CHARACTERISTIC CHECKLIST

Please check all that apply:

- ☐ Family history of SMA
- ☐ *SMN1* gene deletion/mutation with unknown *SMN2* copy number
- ☐ Asymptomatic
- ☐ Muscle weakness:
  - ☐ Symmetrical
  - ☐ More proximal than distal
  - ☐ Greater in the legs than in the arms
- ☐ Respiratory issues
- ☐ Bulbar dysfunction
- ☐ Scoliosis
- ☐ Joint contractures
- ☐ Tongue fasciculations
- ☐ Tendon reflexes absent or diminished
- ☐ Spinal rods
- ☐ Spinal fusions
- ☐ Other (e.g., EMG results; please specify): _____

RE-REQUISITION
Invitae offers 1 re-requisition at no additional charge within 90 days for genes within the original clinical area. For more information and to request online, please visit **www.invitae.com/re-requisition**.

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), with custom validated methods for *SMN1/SMN2* analysis. For details on the analysis of *SMN1/SMN2* please visit **www.invitae.com/en/physician/tests/03245/**.

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).

TESTS INCLUDED IN THE PROGRAM

Test code	Test name	# of genes	Gene list
○ 03245	Invitae Spinal Muscular Atrophy Panel	2	*SMN1, SMN2*

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 SMA Identified Program, 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), has been informed that de-identified Patient data may be used and shared for research purposes and shared with third parties, including Biogen, Inc. The medical professional warrants that he/she will not seek reimbursement for this sponsored test from any third party, including but not limited to 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 Biogen, Inc. that may contact you directly in connection with the SMA Identified 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 law to order this test.

Medical professional signature	Date

