INVITAE **HYPOPHOSPHATEMIA**

Sponsored Testing Program Eligibility Criteria

FM153-1

Patients who are suspected of having a genetic hypophosphatemic disorder*, or who have been clinically diagnosed with X-Linked Hypophosphatemia (XLH), are invited to take part in the sponsored Hypophosphatemia Testing Program brought to you by Ultragenyx Pharmaceutical Inc. 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/hypophosphatemia.

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.

**Hypophosphatemic disorders are referred to as X-linked hypophosphatemia (XLH), X-linked hypophosphatemic rickets, hereditary hypophosphatemic rickets, familial hypophosphatemic rickets, vitamin D-resistant rickets (VDRR), vitamin D-resistant osteomalacia, X-linked vitamin D-resistant rickets, hypophosphatemic rickets, hypophosphatemic vitamin D-resistant rickets (HPDR), genetic rickets, or familial hypophosphatemia.*

Patient name	Date of birth (MM/DD/YYYY)

HYPOPHOSPHATEMIA ELIGIBILITY CRITERIA

The patient must be aged 1 year or older

☐ EITHER with a completed CRYSVITA® Start Form

OR

☐ have a previous diagnosis related to hypophosphatemia*

OR

Exhibit two or more of the following clinical signs and/or symptoms:

- ☐ Family member of a confirmed XLH patient
- ☐ Short stature
- ☐ Lower limb deformities
- ☐ Fractures/pseudo-fractures
- ☐ Tooth abscesses and/or excessive dental caries
- ☐ Bone, joint pain, and/or joint stiffness
- ☐ Muscle pain, weakness, and/or fatigue
- ☐ Gait abnormalities

OPTIONAL INFORMATION:

Biochemical markers (optional):

	Patient value/reference range
☐ Reduced serum phosphate (<LLN)	_____ /_____
☐ Reduced TmP/GFR (<LLN)	_____ /_____

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 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 retain a written copy of the consent and produce it upon request, and 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 organization and clinician contact information provided in the order may be shared with third parties, including Ultragenyx, that may contact the medical professional directly in connection with the Program, and that they have made the Patient aware that third parties including Ultragenyx may contact their medical professional regarding de-identified information gathered through the Program. For orders originating outside the United States, the Patient has been informed that their personal information and specimen will be transferred to and processed in the United States and that de-identified Patient data may be used and shared for research purposes in the United States. 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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