INVITAE KIDNEYCODE

ORDER ID
For Invitae internal use only

Requisition Form
KIDNEYCODE TRF TRF951-1

This requisition form can be used to submit a specimen for the KIDNEYCODE program, a complimentary Invitae Progressive Renal Disease Panel U.S. testing program brought to you by Reata Pharmaceuticals and Invitae Corporation. Please confirm that the patient meets the eligibility requirements for the 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.

PROGRAM ELIGIBILITY:

This program is available to patients in the U.S. with (please check all that apply):

☐ eGFR ≤ 90mL/min/1.73m^2

AND

At least one of the following (check all that apply):

☐ Hematuria

☐ Family history of kidney disease

☐ Biopsy confirming FSGS

OR

☐ Family member with a confirmed or suspected diagnosis of Alport syndrome or Focal Segmental Glomerulosclerosis (FSGS)

PATIENT INFORMATION

First name	MI	Last name
Date of birth (MM/DD/YYYY)	Biological 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		
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

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.*

Special cases : ◯ History of/current hematologic malignancy

REASON FOR TESTING

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

PRACTICE INFORMATION

Practice name and address

Institution/practice name		
Phone		Fax
Address		City
State	Zip code	Country

Primary clinical contact

		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 CKD

REATA KIDNEYCODE PROGRAM CLINICAL INFORMATION

Medical history (check all that apply):

☐ Hypertension
☐ Type 1 diabetes
☐ Type 2 diabetes
☐ Cardiovascular disease
☐ Hearing loss
☐ Eye disease that is NOT related to vision correction
☐ Renal replacement therapy
  ☐ Dialysis ☐ Transplant
☐ Had kidney biopsy (if yes, enter diagnosis below)
  Diagnosis: _____

FAMILY VARIANT TESTING

Invitae's family variant testing programs involve 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 PROBAND RQ#	RELATIONSHIP TO PROBAND	GENE(S)	VARIANT(S)

INVITAE

REATA KIDNEYCODE PROGRAM CLINICAL INFORMATION (continued)

Has patient ever been diagnosed with any of the following forms of CKD:

- ☐ Diabetic related
- ☐ Hypertension related
- ☐ IgA nephropathy
- ☐ FSGS
- ☐ Alport syndrome
- ☐ APDKD
- ☐ Familial hematuria
- ☐ Benign familial hematuria
- ☐ Congenital familial hematuria
- ☐ Benign hereditary nephritis
- ☐ Thin basement membrane disease

Family history of CKD (check all that apply):

- ☐ Mother
- ☐ Father
- ☐ Son
- ☐ Daughter
- ☐ Sibilings
- ☐ Maternal grandmother or grandfather
- ☐ Paternal grandmother or grandfather

Lab values (most recent):

Serum creatinine _____mg/dL

eGFR _____mL/min/1.73m^2

Urine albumin (ACR) _____ or Urine Protein (PCR) _____

Is the patient:

- ☐ Commercially insured
- ☐ Federally insured (Medicare, Medicaid, SCHIP, DOD TRICARE, VHA, or IHS)
- ☐ Uninsured

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

SHIPPING INSTRUCTIONS

Please ship specimen to Invitae:

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

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**.

TEST OPTIONS

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
◯ 75000	Invitae Progressive Renal Disease Panel	17	*ACTN4, ANLN, CD2AP, COL4A3, COL4A4, COL4A5, CRB2, HNF1A, INF2, LMX1B, MYO1E, NPHS1, NPHS2, PAX2, PKD2, PKHD1, TRPC6*

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 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 Reata Pharmaceuticals, that may contact the medical professional directly in connection with the Program, and that they have made the Patient aware that third parties including Reata Pharmaceuticals 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 (required)	Date