Ambry Genetics®
A Konica Minolta Company

PTC THERAPEUTICS™

Test Requisition Form

COMPLETE ENTIRE FORM AND SUBMIT PEDIGREE/CLINIC NOTES TO AVOID DELAYS

Project code: PHRPTC-150300

To submit an order via email, please send the completed test requisition form to info@ambrygen.com

PATIENT INFORMATION

Name (Last, First, MI)	Sex at Birth ☐F ☐M	Date of Birth (MM/DD/YY)
Ethnicity: ☐African American ☐Asian ☐White ☐Hispanic ☐Jewish ☐Other:		

Address	City	State	Zip
Phone	Email		

SPECIMEN INFORMATION*

☐Blood ☐Saliva ☐Send saliva kit to patient** ☐Phlebotomy request^ ☐Personal history of allogenic bone marrow or peripheral stem cell transplant*

Collection Date	Specimen ID	Medical Record #

** Blood/saliva from patients with a history of allogenic bone marrow or stem cell transplant cannot be used for genetic testing. Blood/saliva from patients with active hematological disease is not recommended. An alternative specimen may be needed. Please see ambrygen.com/specimen-requirements for details.*
*** By checking this box and submitting the completed form, a saliva kit will be sent to the patient's address above. Your patient will be able to submit a saliva sample directly to Ambry for testing.*
^ Available for US patients only. As the patient's clinician, I am unaware of any potential for complication or difficulty in drawing blood for the listed patient(s). I understand that the phlebotomist has full authority to refuse to draw any patient if the safety of the phlebotomist and/or patient(s) are in question.

Billing Facility
PTC Therapeutics (31786) Attn: Accounts Payable 100 Corporate Court, South Plainfield, NJ 07080

ORDERING PHYSICIAN/SENDING FACILITY (Each listed person will receive a copy of the report)

Facility Name (Facility Code)	Address	City	State /Country	Zip	Phone

Ordering Licensed Provider Name (Last, First)(Code)	NPI#	Phone	Fax/Email

Additional Results Recipients

Genetic Counselor or Other Medical Provider Name (Last, First) (Code)	Phone/Fax/Email

PATIENT ELIGIBILITY

Both congenital hypotonia **AND** at least one of the following movement disorders must be observed in the patient. Patients who meet one of the exclusion criteria below are NOT eligible for this sponsored program.

Inclusion Criteria (Please check all conditions that apply and indicate symptom age of onset)

Check if Applicable	Clinical Symptom	Age of Onset
Congenital Hypotonia (must be observed)		
☐	Congenital Hypotonia	
Movement Disorders		
☐	Dystonia (facial, torso, or limb)	
☐	Dyskinesia (hyperkinesia, chorea, athetosis)	
☐	Oculogyric crises/paroxysmal movements	
☐	Hypokinesia or bradykinesia	
☐	Myoclonus	
☐	Tremor	

Additional Symptoms (Please check all that apply and indicate symptom age of onset)

Check if Applicable	Clinical Symptom	Age of Onset
☐	Developmental Delay (motor, cognitive, or speech impairment)	
☐	Autonomic Dysfunction	
☐	Gastrointestinal Issues	
☐	Seizures	
☐	Sleep Disturbances	
☐	Other: _____ _____	

Exclusion Criteria (DO NOT send if any of these are met)

- Patient had CSF neurotransmitter test with normal results
- Patient had whole exome sequencing performed
- Patient had sequencing panel or single gene test containing DDC gene

Check to Order	Test Name	Test Code	# of Genes	Gene List
☐	Movement Disorders + Hypotonia Panel	6867	81	*AARS, ABAT, ADCY5, ALDH5A1, ALDH7A1, AMT, AP1S2, ARHGEF9, ATP1A2, ATP1A3, ATP7B, BCKDHA, BCKDHB, COASY, DBT, DDC, DDX3X, DLD, DNAJC12, DNM1, EIF2AK2, ELP2, GAMT, GCDH, GCH1, GLDC, GLRA1, GLRB, GNAO1, GNB1, HPRT1, KCNB1, KCNMA1, KMT2B, MECR, MYBPC1, NBEA, NGLY1, NTNG2, PANK2, PCCA, PCCB, PDE10A, PGAP1, PLA2G6, PNKD, PNPO, PNPT1, PRRT2, PTS, QDPR, RHOBTB2, SCN2A, SCN8A, SERAC1, SGCE, SLC16A2, SLC17A5, SLC18A2, SLC2A1, SLC30A10, SLC39A14, SLC6A3, SLC6A5, SLC6A8, SLC9A6, SPR, SYT1, TET3, TH, TNR, TOR1A, TUBB4A, UBTF, VAC14, VAMP2, VPS13D, WARS2, WDR45, WDR73, YIF1B*
☐	Reflex to NeurodevelopmentNext-*Expanded*™	6860	>1400	**Not included in sponsored program – must submit insurance or patient self-pay information; Ambry representative will reach out to discuss options**
☐	Reflex to ExomeNext®	(Multiple options)	~20,000	**Not included in sponsored program – must submit insurance or patient self-pay information; Ambry representative will reach out to discuss options**

CONFIRMATION OF MEDICAL NECESSITY AND INFORMED CONSENT FOR SPONSORED GENETIC TESTING

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 Ambry Genetics' Informed Consent for Genetic Testing and in connection with the Program, and has been informed that Ambry Genetics 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-charge 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 commercial organizations, that may contact the medical professional directly in connection with the Program, and that they have made the Patient aware that de-identified Patient data may be used and shared with such third parties, for purposes which include contacting their medical professional directly in connection with the Program. A list of third party partners may be provided upon request. I attest that I am authorized under applicable state law to order this test.

PTC Therapeutics, and the company or companies that help PTC Therapeutics administer the services, request and receive anonymized data (not personally identifiable data) and the results related to the testing necessary to complete publications and or retrospective reviews for the purposes of publishing studies, including entering and maintaining anonymized health information in a database. Patient identifiers are known only to the requesting physician/institution.

Signature Required for Processing Medical Professional Signature: Date:

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