Ambry Genetics | hATTR Compass™ Genetic Testing

Partner Code: 120110

Test Requisition Form

To submit an order via email, please send the completed test requisition form to info@ambrygen.com
OR Fax to +1.949.900.5501

PATIENT INFORMATION (Patient must be 18 years or older)

Name (Last, First, MI)	Date of Birth (MM/DD/YY)	Phone Number	Email

Address	City	State	Zip	Sex at Birth	Ethnicity
				☐F ☐M	☐African American ☐Asian ☐Caucasian ☐Hispanic ☐Jewish ☐Other:

NO-COST GENETIC COUNSELING

Genetic Counseling: Ambry and Ionis Pharmaceuticals, Inc., have partnered with a third-party counseling provider to offer no cost, pre- and/or post-test genetic counseling for your patients. Genetic counseling is not required for testing. By checking the boxes below, I agree to allow Ambry to facilitate the provision of pre-test and/or post-test genetic counseling services by a third-party counseling provider. If genetic counseling is requested, please provide copy of clinic notes.

☐ Yes. I request a pre-test genetic counseling session for my patient. ☐ Yes. I request a post-test genetic counseling session for my patient.

ALL patients requesting counseling (with negative, positive or VUS result) will be contacted via phone and/or email.

SPECIMEN INFORMATION*

Type(s) ☐ Blood ☐ Buccal Swab ☐ Saliva ☐ Send kit to patient** ☐ Phlebotomy request^

☐ Personal history of allogenic bone marrow or peripheral stem cell transplant (not eligible for testing)

Collection Date	Specimen ID	Medical Record #

*Blood/saliva/buccal swab from patients with a history of allogenic bone marrow or stem cell transplant cannot be used for genetic testing. Blood/saliva/buccal swab from patients with active hematological disease is not recommended. An alternative specimen may be needed. See ambrygen.com/specimen-requirements for details.

**By checking this box and submitting the completed form, a kit will be sent to the patient's address above. Your patient will be able to submit a 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.

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 **(for *TTR* results only)**	Fax **(for results)**	Email **(for results)**

Additional Results Recipients

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

TEST ORDER

Please select only one test. Tests available in US, Canada and Puerto Rico.

If there is a blood related family member with a positive TTR genetic test report, Specific Site Analysis test is recommended. Indicate relative's name and date of birth.

The following is required when ordering known mutation analysis for a mutation identified in an outside laboratory:

- **Affected Family Member report (mandatory)**
- **Positive control (recommended)**

Name _____ **DOB** _____

Check To Order	Test Name	Test Code	# of Genes	Gene List		
☐	Transthyretin amyloidosis	1560	1	*TTR*		
☐	NeuropathySelect (includes *TTR*)	9570	81	***TTR***, *AARS, AIFM1, APOA1, ATL1, ATL3, ATP7A, BICD2, BSCL2, CHCHD10, DCTN1, DNAJB2, DNM2, DNMT1, DST, DYNC1H, EGR2, FAM134B , FBXO38, FGD4, FIG4, FUS, GAN, GARS, GDAP1, GJB1, GNB4, GSN, HARS, HINT1, HSPB1, HSPB8, IGHMBP2, IKBKAP , INF2, KIF1A, LITAF, LMNA, LRSAM1, MARS, MFN2, MORC2, MPZ, MTMR2, NDRG1, NEFH, NEFL, NGF, NTRK1, OPTN, PDK3, PLEKHG5, PMP22, PRDM12, PRPS1, PRX, RAB7A, REEP1, SBF2, SCN10A, SCN11A, SCN9A, SETX, SH3TC2, SIGMAR1, SLC25A46, SLC52A2, SLC52A3, SLC5A7, SPG11, SPTLC1, SPTLC2, TARDBP, TFG, TRPV4, UBA1, VAPB, VRK1, WNK1, YARS, VCP*		
☐	CardioNext® (includes *TTR*)	8911	92	***TTR***, *ABCC9, ACTC1, ACTN2, AKAP9, ALMS1, ALPK3, ANK2, ANKRD1, BAG3, CACNA1C, CACNA2D1, CACNB2, CALM1, CALM2, CALM3, CASQ2, CAV3, CRYAB, CSRP3, DES, DMD, DOLK, DSC2, DSG2, DSP, EMD, EYA4, FHL1, FKRP, FKTN, FLNC, GATAD1, GLA, GPD1L, HCN4, JPH2, JUP, KCND3, KCNE1, KCNE2, KCNE3, KCNH2, KCNJ2, KCNJ5, KCNJ8, KCNQ1, LAMA4, LAMP2, LDB3, LMNA, MYBPC3, MYH6, MYH7, MYL2, MYL3, MYOZ2, MYPN, NEXN, NKX2-5, PKP2, PLN, PRKAG2, PTPN11, RAF1, RBM20, RIT1, RYR2, SCN10A, SCN1B, SCN2B, SCN3B, SCN4B, SCN5A, SNTA1, SOS1, TAZ, TBX20, TBX5, TCAP, TECRL, TGFB3, TMEM43, TNNC1, TNNI3, TNNT2, TPM1, TRDN, TRPM4, TTN, TXNRD2, VCL*		
☐	TTR Specific Site Analysis	1562		Name and date of birth of relative tested at Ambry	Ambry Accession #	Variant to be tested

Please complete page 2 of 2

Ambry Genetics | hATTR Compass™ Genetic Testing

Patient Name: _____

DOB: _____

Partner Code: 120110

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PATIENT ELIGIBILITY: Patients must be 18 years and older and have a family history of hereditary ATTR amyloidosis OR have at least 2 of the **BOLD** symptoms consistent with hereditary ATTR amyloidosis with polyneuropathy OR a positive biopsy for amyloidosis

SYMPTOM CHECKLIST (Please check all conditions that apply)

Does the patient have a family history of hereditary ATTR amyloidosis?

☐ Yes ☐ No ☐ Patient does not know

If prior TTR positive genetic testing completed in family, please indicate relative's name and date of birth:

Name _____ DOB _____

☐ **Sensory dysfunction:** Age of Onset:_____
- ☐ numbness and tingling in feet and/or hands
- ☐ sensitivity to pain and temperature
- ☐ pain in extremities

☐ **Motor dysfunction:** Age of Onset:_____
- ☐ muscle weakness
- ☐ impaired balance
- ☐ difficulty walking

☐ **Autonomic dysfunction:** Age of Onset:_____
- ☐ orthostatic hypotension
- ☐ early satiety
- ☐ nausea and vomiting
- ☐ changes in GI motility
- ☐ erectile dysfunction
- ☐ bladder dysfunction

☐ **Gastrointestinal:** Age of Onset:_____
- ☐ diarrhea or constipation not responding to typical therapy
- ☐ alternating bouts of diarrhea/constipation

☐ **Heart disease:** Age of Onset:_____
- ☐ shortness of breath
- ☐ edema
- ☐ fatigue
- ☐ palpitations
- ☐ arrhythmias

☐ **Renal issues:** Age of Onset:_____
- ☐ proteinuria
- ☐ renal insufficiency/failure

☐ **Bilateral carpal tunnel syndrome:** Age of Onset:_____

☐ **Lumbar spinal stenosis:** Age of Onset:_____

☐ **Unintentional weight loss:** Age of Onset:_____

☐ **Myocardial radiotracer (^{99m}Tc-PYP/DPD/HMDP) uptake on bone scintigraphy and the absence of a monoclonal protein in serum or urine:** Age of Onset:_____

☐ **Positive biopsy for amyloidosis:** Age of Onset:_____

Approximately, how many doctors has the patient seen about this condition? _____

CONFIRMATION OF INFORMED CONSENT AND MEDICAL NECESSITY FOR GENETIC TESTING

The undersigned person (or representative thereof) ensures he/she is a licensed medical professional authorized to order genetic testing and confirms that the patient has given appropriate informed consent for genetic testing. I confirm testing is medically necessary, and test results may impact medical management for the patient. All information on this ordering form is true to the best of my knowledge. In connection with the hATTR Compass program, I have informed the patient that Ambry Genetics may notify me, the ordering medical professional, of clinical updates related to genetic test results. I have also informed the patient that de-identified patient data may be used and shared with third parties, including Ionis Pharmaceuticals, Inc., for research and commercial purposes. For orders originating in Canada, I have informed the patient 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 and commercial purposes in the United States. I warrant that I will not seek reimbursement for this sponsored test from any third party, including but not limited to U.S. federal healthcare programs. I also acknowledge that organization and clinician contact information provided in the order may be shared with third parties, including Ionis Pharmaceuticals, Inc., and I hereby consent that such parties may contact me directly in connection with the hATTR Compass program, Ionis Pharmaceuticals Inc.'s products, or on-going or potential clinical trials sponsored by Ionis Pharmaceuticals, Inc. I understand that the use of this sponsored test is not intended to be, nor should it be construed as, either express or implied, an obligation or inducement for me to recommend, purchase, order, prescribe, promote, administer or otherwise support any Ionis Pharmaceuticals Inc.'s product or any other Ambry Genetics product or service.

Signature Required for Processing Medical Professional Signature: Date:

To request a complimentary specimen collection kit visit: **ambrygen.com/hattr-compass-kits**

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