Ambry Genetics® A TEMPUS COMPANY | arrowhead pharmaceuticals

Arrowhead FCSNext Test Requisition Form

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

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

Project code: PHRARH-150716

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 ☐Buccal Swab ☐Saliva ☐Send 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.*

*** Please check which specimen type (buccal swab or saliva) to ship to patient's home. Your patient will be able to submit a buccal swab or 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

Arrowhead (45502)

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 (Seventeen years of age and older AND a fasting triglyceride level of >600 mg/dl [>6.77 mmol/L] in the past 12 months)

Inclusion Criteria (Please check all conditions that apply and indicate symptom age of onset)		**Additional Symptoms** (Please check all that apply)	**Exclusion Criteria** (DO NOT send if any of these are met)
Clinical Symptom	Check if Applicable	Clinical Symptom	• Prior genetic testing for FCS • < 17 years of age
Must Be Observed and Filled Out	☐	History of pancreatitis	
Fasting triglyceride level (in past 12 months) > 600mg/dL _____ **mg/dL** OR >6.77 mmol/L _____ **mmol/L**	☐	Severe recurrent abdominal pain	
	☐	Family history of pancreatitis or FCS	

Check to Order	Test Name	Test Code	# of Genes	Gene List
☐	FCSNext	8920	5	*APOA5, APOC2, GPIHBP1, LMF1, LPL*

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.

Signature Required for Processing Medical Professional Signature: Date:

SUBMIT PEDIGREE/CLINIC NOTES TO AVOID DELAYS

7 Argonaut, Aliso Viejo, CA 92656 USA Toll Free +1.866.262.7943 Fax +1.949.900.5501 **ambrygen.com**

MKT-PHAR-TRF-20029-EN v1 09.22.25