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

SPECIMEN INFORMATION

☐ Buccal Swab ☐ Send kit to patient*

☐ Personal history of allogenic bone marrow or peripheral stem cell transplant

Collection Date	Specimen ID	Medical Record #

** Please check the box to request a kit be sent to the patient's home. Your patient will be able to submit a buccal swab directly to Ambry for testing.*

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

PATIENT ELIGIBILITY

Inclusion Criteria: Patient must be 17 years of age or older AND have a fasting triglyceride level of >600 mg/dl in the past 12 months. The triglyceride level must be provided below to be eligble for the program.

Fasting triglyceride level (in past 12 months)

> 600mg/dL _____ **mg/dL**

Age of onset of increased triglycerides (if known): _____

Additional Clinical Symptoms (Please check all that apply)

Check if Applicable	Clinical Symptom
☐	Patient history of pancreatitis
☐	Patient history of severe recurrent abdominal pain
☐	Family history of pancreatitis or FCS

Exclusion Criteria

- Prior genetic testing for FCS
- < 17 years of age

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:

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

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