Ambry Genetics | HoFH GENETIC TESTING PROGRAM

Test Requisition Form

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

Project code: PHRRGE 150630 REGN HoFH PIP

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: ☐ Asian ☐ Ashkenazi Jewish ☐ Black/African American ☐ White ☐ French Canadian/Cajun ☐ Hispanic/Latino ☐ Mediterranean ☐ Middle Eastern ☐ Native American ☐ Pacific Islander ☐ Portuguese ☐ Unknown ☐ Other:

Address	City	State	Zip

Phone	Email

Guardian Name	Patient/Guardian Phone	Patient/Guardian Email

NO-COST GENETIC COUNSELING

Genetic Counseling: Ambry has partnered with a third-party counseling provider to offer no cost, pre-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 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. **Patients requesting counseling will be contacted via phone and/or email.**

SPECIMEN INFORMATION*

Sample Type: ☐ Saliva Collection Assistance: ☐ Send Saliva Kit to Patient ☐ Personal history of allogenic bone marrow or peripheral stem cell transplant*

Collection Date If date of collection is not provided, three calendar days before specimen receipt will be used (for specimens stored longer than 30 days, the day of archive retrieval will be used as the date of service)	Specimen ID	Medical Record #

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

BILLING FACILITY

REGN HoFH PIP 39270

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 (Patients must meet one criteria from Part A **AND** one from Part B to qualify for the program)

The Uncover HoFH genetic testing program is only available to patients located in the United States.

Part A: (one must be checked)	
☐	Untreated LDL-C >300 mg/dL
☐	Treated LDL-C >250 mg/dL on one lipid-lowering therapy
☐	Treated LDL-C >200 mg/dL on two or more lipid-lowering therapies
☐	Other LDL-C level and treatment profile consistent with homozygous familial hypercholesterolemia (HoFH)

Part B: (one must be checked)	
☐	Family History of familial hypercholesterolemia (FH) or premature coronary artery disease (<55 yrs for males and <65 yrs for females)
☐	Personal History of premature coronary artery disease (<55 yrs for males and <65 yrs for females)
☐	Personal History of tendonous and or cutaneous xanthomas
☐	Personal History of corneal arcus before age 45 years
☐	Personal History of aortic stenosis

Check to Order	Test Name	Test Code	# of Genes	Gene List
☐	FHNext®	8680	4	*APOB, LDLR, PCSK9, LDLRAP1*

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. 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 Regeneron Pharmaceuticals Inc., for research and commercial purposes. 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 Regeneron Pharmaceuticals, and I hereby consent that such parties may contact me directly in connection with this testing program, Regeneron Pharmaceuticals' products, or on-going or potential clinical trials sponsored by Regeneron Pharmaceuticals. 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 Regeneron Pharmaceuticals product or any other Ambry Genetics product or service.

☐ For NY Residents: By checking this box, I agree that Ambry Genetics will retain my sample for 6 months after the testing above has been completed. By not checking this box, I understand that under New York State law, Ambry Genetics must discard my sample after the longer of (a) testing completion and (b) 60 days after the Date of Collection above.

Signature Required for Processing Medical Professional Signature: Date:

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

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