

Partner Code: 120110

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 <input type="checkbox"/> F <input type="checkbox"/> M
Ethnicity: <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Jewish <input type="checkbox"/> Other:				

NO-COST GENETIC COUNSELING
<p><b>Genetic Counseling:</b> Ambyr and Akcea 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 Ambyr 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.</p> <p><input type="checkbox"/> Yes. I request a pre-test genetic counseling session for my patient. <input type="checkbox"/> Yes. I request a post-test genetic counseling session for my patient.</p> <p><b>ALL patients requesting counseling (with negative, positive or VUS result) will be contacted via phone and/or email.</b></p>

SPECIMEN INFORMATION*		
Type(s) <input type="checkbox"/> Blood <input type="checkbox"/> Buccal Swab <input type="checkbox"/> Saliva <input type="checkbox"/> Send kit to patient** <input type="checkbox"/> Phlebotomy request*	<input type="checkbox"/> 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](http://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 Ambyr 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			
<input type="checkbox"/>	Transthyretin amyloidosis	1560	1	TTR			
<input type="checkbox"/>	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, GDAPI, 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			
<input type="checkbox"/>	CardioNext® (includes TTR)	8911	92	TTR, ABCC9, ACTC1, ACTN2, AKAP9, ALMS1, ALPK3, ANK2, ANKRD1, BAG3, CACNA1C, CACNA2D1, CACNB2, CALM1, CALM2, CALM3, CASQ2, CAV3, CRYAB, CSR3, 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, TNNT2, TPM1, TRDN, TRPM4, TTN, TXNRD2, VCL			
<input type="checkbox"/>	TTR Specific Site Analysis	1562		<table border="1"> <tr> <td>Name and date of birth of relative tested at Ambyr</td> <td>Ambyr Accession #</td> <td>Variant to be tested</td> </tr> </table>	Name and date of birth of relative tested at Ambyr	Ambyr Accession #	Variant to be tested
Name and date of birth of relative tested at Ambyr	Ambyr Accession #	Variant to be tested					

## Page 2 Required

**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)**

<p>Does the patient have a family history of hereditary ATTR amyloidosis?  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Patient does not know</p> <p>If prior TTR positive genetic testing completed in family, please indicate relative's name and date of birth:        Name _____ DOB _____</p> <p><input type="checkbox"/> <b>Sensory dysfunction:</b> Age of Onset: _____  <input type="checkbox"/> numbness and tingling in feet and/or hands  <input type="checkbox"/> sensitivity to pain and temperature  <input type="checkbox"/> pain in extremities</p> <p><input type="checkbox"/> <b>Motor dysfunction:</b> Age of Onset: _____  <input type="checkbox"/> muscle weakness  <input type="checkbox"/> impaired balance  <input type="checkbox"/> difficulty walking</p> <p><input type="checkbox"/> <b>Autonomic dysfunction:</b> Age of Onset: _____  <input type="checkbox"/> orthostatic hypotension  <input type="checkbox"/> early satiety  <input type="checkbox"/> nausea and vomiting  <input type="checkbox"/> changes in GI motility  <input type="checkbox"/> erectile dysfunction  <input type="checkbox"/> bladder dysfunction</p> <p><input type="checkbox"/> <b>Gastrointestinal:</b> Age of Onset: _____  <input type="checkbox"/> diarrhea or constipation not responding to typical therapy  <input type="checkbox"/> alternating bouts of diarrhea/constipation</p>	<p><input type="checkbox"/> <b>Heart disease:</b> Age of Onset: _____  <input type="checkbox"/> shortness of breath  <input type="checkbox"/> edema  <input type="checkbox"/> fatigue  <input type="checkbox"/> palpitations  <input type="checkbox"/> arrhythmias</p> <p><input type="checkbox"/> <b>Renal issues:</b> Age of Onset: _____  <input type="checkbox"/> proteinuria  <input type="checkbox"/> renal insufficiency/failure</p> <p><input type="checkbox"/> <b>Bilateral carpal tunnel syndrome:</b> Age of Onset: _____</p> <p><input type="checkbox"/> <b>Lumbar spinal stenosis:</b> Age of Onset: _____</p> <p><input type="checkbox"/> <b>Unintentional weight loss:</b> Age of Onset: _____</p> <p><input type="checkbox"/> <b>Myocardial radiotracer (<sup>99m</sup>Tc-PYP/DPD/HMDP) uptake on bone scintigraphy and the absence of a monoclonal protein in serum or urine:</b> Age of Onset: _____</p> <p><input type="checkbox"/> <b>Positive biopsy for amyloidosis:</b> Age of Onset: _____</p> <p><input type="checkbox"/> <b>Other symptom(s) of hATTR</b>        _____</p> <p>Approximately, how many doctors has the patient seen about this condition? _____</p>
---	--

**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 Ambyr 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 Akcea Therapeutics, Inc. and its parent company, 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 Akcea Therapeutics, Inc. and its parent company, Ionis Pharmaceuticals, Inc., and I hereby consent that such parties may contact me directly in connection with the hATTR Compass program, Akcea Therapeutics Inc.'s products, or on-going or potential clinical trials sponsored by Akcea Therapeutics, Inc. or 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 Akcea Therapeutics Inc.'s or Ionis Pharmaceuticals Inc.'s product or any other Ambyr Genetics product or service.

<b>Signature Required for Processing</b> Medical Professional Signature: _____	Date: _____
--	-------------

To request a complimentary specimen collection kit visit: [ambrygen.com/hattr-compass-kits](http://ambrygen.com/hattr-compass-kits)