PREVENTION GENETICS
part of EXACT SCIENCES

Krystal®

PREVENTIONGENETICS USE ONLY

All testing must be ordered by a qualified Healthcare Provider

THIS FORM MUST ACCOMPANY ALL SPECIMENS

FOR PATIENT SELF COLLECTING A SAMPLE, CHOOSE ONE:
☐ Ship one Saliva GeneFiX™ Saliva Collection kit to patient's address.
☐ Ship one Buccal OCD-100 kit to patient's address.

SPECIAL PROJECT - TEST REQUISITION FORM

SP288 - KRYSTAL BIOTECH - DECODE DEB

SPONSORED TESTING PROGRAM

PERSON COMPLETING FORM	CONTACT (PHONE AND EMAIL)	DATE OF REQUEST (MM/DD/YYYY)

PATIENT INFORMATION

LAST (FAMILY) NAME	FIRST NAME	MI	DATE OF BIRTH (MM/DD/YYYY)

ADDRESS	CITY	STATE	ZIP

EMAIL	PHONE NUMBER	GEOANCESTRY / ETHNICITY
		☐ Asian ☐ Black/African American ☐ White/Caucasian ☐ Ashkenazi Jewish ☐ Hispanic ☐ Native American ☐ Pacific Islander ☐ French Canadian ☐ Sephardic Jewish ☐ Mediterranean ☐ Other: _____
MEDICAL RECORD NUMBER (MRN)	**SPECIMEN COLLECTION DATE (MM/DD/YYYY)** If no collection date is provided, date of receipt will be used.	
HAS PATIENT BEEN TESTED PREVIOUSLY AT PreventionGenetics? ☐ NO ☐ YES, PG ID# _____	**SPECIMEN SOURCE** ☐ Blood ☐ Saliva ☐ Buccal ☐ Extracted DNA	**BIOLOGICAL SEX** ☐ Male ☐ Female ☐ Other _____ *SPECIFY KARYOTYPE*
HAS PATIENT'S RELATIVE BEEN TESTED AT PreventionGenetics? ☐ NO ☐ YES, provide _____ *NAME* _____ *DATE OF BIRTH* _____ *RELATIONSHIP TO PATIENT* _____ *or PreventionGenetics ID NUMBER*	**BLOOD TRANSFUSION** ☐ NO ☐ Within Last 30 Days, DATE _____ *MM/DD/YYYY* TYPE _____	**BONE MARROW TRANSPLANT** ☐ NO ☐ Within Last 30 Days, DATE _____ *MM/DD/YYYY* TYPE _____

CLINICAL HISTORY

Current Diagnosis *(SELECT ONE)*

☐ Epidermolysis bullosa simplex
☐ Dystrophic epidermolysis bullosa
☐ Junctional epidermolysis bullosa
☐ Kindler epidermolysis bullosa
☐ Epidermolysis bullosa, type unknown
☐ Other (specify)_____

Method of Diagnosis *(SELECT ALL THAT APPLY)*

☐ Clinical symptoms
☐ Immunofluorescence microscopy
☐ Transmission electron microscopy
☐ Other (specify)_____

Age of first symptom onset

_____ ☐ Years ☐ Months ☐ Unknown

Family history of EB *(SELECT ONE)*

☐ Appears consistent with autosomal dominant inheritance of EB
☐ Appears consistent with autosomal recessive inheritance of EB
☐ No known family history of EB
☐ Unknown

ELIGIBILITY CRITERIA

The Ordering Provider attests the Patient is eligible for the Program, which is available to Patients who meet all three of the criteria listed below:

1. The Patient must reside in the United States or Puerto Rico
2. The Patient must have clinical symptoms consistent with epidermolysis bullosa (EB)
3. The Patient must not have had prior genetic testing for EB in a clinical laboratory

TEST SELECTION

TEST CODE	TEST NAME	DESCRIPTION
☐ **15787**	**Next Gen Krystal Biotech-I DEB SP288 panel**	*CD151, CDSN, CHST8, COL17A1, COL7A1, CSTA, DSG1, DSP, DST, EXPH5, FERMT1, ITGA3, ITGA6, ITGB4, JUP, KLHL24, KRT1, KRT5, KRT10, KRT14, LAMA3, LAMB3, LAMC2, PKP1, PLEC, SERPINB8, TGM5*
☐ **100**	**Family follow-up targeted testing**	Gene(s): ***COL7A1*** Variant(s) or comments: Proband Info: Relationship to Proband:

COMMENTS

SPECIAL INSTRUCTIONS

SP288

☐ **SPECIMEN COLLECTED IN NEW YORK STATE**
Include Genetic Testing Healthcare Provider Statement and New York State Non-Permitted Laboratory Test Request approval letter if test is not NY state approved. For a list of NY state approved tests, see website.

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Test information is available on our website:
PreventionGenetics.com

PROVIDER CONSENT

By signing below, you, the Healthcare Provider, agree you have obtained the patient's (or parent/guardian's if patient is a minor) informed consent to perform this test, and confirm the patient has been appropriately counseled and understands the risks, benefits, and limitations of this genetic testing and the implications of the results. You further confirm the patient authorizes PreventionGenetics to use and disclose de-identified patient test data and results ("De-identified Data") to promote research and improve the diagnosis and treatment of the genetic diseases. The De-identified Data may be used for research purposes as well as to facilitate and improve the diagnosis of genetic changes and diseases in other patients. For these reasons, PreventionGenetics may disclose De-identified Data with external physicians, scientists, researchers and pharmaceutical companies. No protected health information will be shared. As the Healthcare Provider, you hereby authorize PreventionGenetics to share your name, institution, address, and contact information with Krystal Biotech, and consent to Krystal Biotech contacting you.

HEALTHCARE PROVIDER SIGNATURE	PRINTED NAME	DATE

PROVIDER INFORMATION AND REPORTING

Our preferred method of report transmission is uploading to our secure web portal, myPrevent.
Please provide an email address, when possible. If you have additional specific reporting requests, indicate them BELOW.

PROVIDER INFORMATION

INSTITUTION

ADDRESS	**CITY**	**STATE**	**ZIP**

REQUESTING PHYSICIAN (First, Last, Degree)	**REQUESTING GENETIC COUNSELOR OR ALLIED PROVIDER** (First, Last, Degree)
EMAIL ADDRESS (For report access via myPrevent)	**EMAIL ADDRESS** (For report access via myPrevent)

PHONE NUMBER	**NPI# (US ONLY)**	**PHONE NUMBER**	**NPI# (US ONLY)**

IF YOU REQUIRE REPORTS TO BE TRANSMITTED VIA ANOTHER SECURE METHOD, SPECIFY HERE.

LIST ADDITIONAL HEALTHCARE PROVIDERS AND THEIR EMAILS TO ALLOW ACCESS TO REPORTS

INSTITUTIONAL BILLING

BILLING ID KRYSTAL10288

SPECIAL PROJECT NUMBER **SP288**

SPECIMEN REQUIREMENTS / SHIPPING AND HANDLING INSTRUCTIONS

Label all specimen containers with the patient's name, date of birth, and/or ID number. At least two identifiers should be listed on specimen containers. Specimen deliveries are accepted Monday-Saturday for all specimen types. Holiday schedules will be posted on our website at least one week prior to major holidays.

WHOLE BLOOD
Requirements: Collect 3 ml - 5 ml of whole blood in EDTA (purple top tube) or ACD (yellow top tube), minimum 1 ml for small infants. Heparin (green top tube) is strongly discouraged.

Shipping: At room temperature or refrigerated, a blood specimen is stable for up to 8 days. Include a refrigerated gel pack in the shipping container. Fresh blood specimens are preferred.

SALIVA
Requirements: Oragene™ or GeneFiX™ Saliva Collection kit used according to manufacturer instructions. DNA from saliva specimens is invariably contaminated with microbial and food DNA, which can impact specimen quality and may result in delayed testing and/or the need for a second specimen.

Additional instructions to help families collecting samples at home are included in each home saliva kit order.

Shipping: Specimens may be shipped at room temperature.

BUCCAL SWAB (OCD-100 Preferred)
Requirements: OCD-100 Buccal Swab used according to manufacturer instructions. Buccal swabs are most appropriate for targeted, known variant testing. DNA from buccal specimens is invariably contaminated with microbial and food DNA, which can impact specimen quality and may result in delayed testing and/or the need for a second specimen.

OCD-100 instructions are available in about 30 different languages. To request special instructions for patients, add a note in the Comments section of the kit order indicating which language is needed and we will do our best to accomodate. Default instructions are English.

Shipping: At room temperature, an OCD-100 buccal specimen is stable for up to 80 days. Specimens may be shipped at room temperature.

For additional questions or concerns, please contact our Client Service Representatives or our Genetic Counseling Team at (715) 387-0484, or email: support@preventiongenetics.com.

SHIPPING ADDRESS
PreventionGenetics - Diagnostic Lab
3800 S. Business Park Ave.
Marshfield, Wisconsin 54449
USA

Comment SP288