

# Skip the paperwork - ORDER THIS TEST ONLINE!

- Avoid paperwork-related testing delays. Online ordering ensures all required fields are completed prior to order submission.
- One website to order, track testing in progress, receive results, and manage customer service inquiries.
- Automatically retain an online version of completed test orders and reports.

## Set up your new account.

Follow these steps:

1. Visit [www.preventiongenetics.com/sponsoredTesting/](http://www.preventiongenetics.com/sponsoredTesting/)
2. Find a sponsored testing program and select **MORE INFORMATION**.
3. If online ordering is available, **SELECT** link in upper right corner of the program web page.
4. Then click on **SIGN UP** to create your new account.
5. Follow the **PROMPTS** to enter your information.
6. A verification email\* will be sent to **CONFIRM** your email address.
7. **WELCOME** to your ordering portal!

\*PreventionGenetics' verification emails may be sent to your spam folder or blocked by your organization's security. To avoid this, add (or reach out to your IT department to add) our notification email address ([no-reply@preventiongenetics.com](mailto:no-reply@preventiongenetics.com)) to your allow list.

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M-US-PG-00331

SPECIAL PROJECT - TEST REQUISITION FORM

**SP317 - Alnylam Act®**

**hATTR Amyloidosis**

SPONSORED TESTING PROGRAM

OR **Scan** this code,



OR **Click** here,

[https://alnylam.  
preventiongenetics.com/](https://alnylam.preventiongenetics.com/)

to go to our Sponsored  
Testing web page!

**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.

PREVENTIONGENETICS USE ONLY

All testing must be ordered  
by a qualified Healthcare Provider

**THIS FORM MUST  
ACCOMPANY ALL SPECIMENS**

## SPECIAL PROJECT - TEST REQUISITION FORM SP317 - Alnylam Act® hATTR Amyloidosis

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	
MEDICAL RECORD NUMBER (MRN)		SPECIMEN COLLECTION DATE (MM/DD/YYYY) If no collection date is provided, date of receipt will be used.		<input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Ashkenazi Jewish <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Middle East/North Africa <input type="checkbox"/> Pacific Islander <input type="checkbox"/> French Canadian <input type="checkbox"/> Sephardic Jewish <input type="checkbox"/> Mediterranean <input type="checkbox"/> Other: _____	
SPECIMEN SOURCE <input type="checkbox"/> Blood <input type="checkbox"/> Saliva <input type="checkbox"/> Buccal		BIOLOGICAL SEX <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other _____ SPECIFY KARYOTYPE _____		BLOOD TRANSFUSION <input type="checkbox"/> NO <input type="checkbox"/> Within last 30 days	
HAS PATIENT BEEN TESTED PREVIOUSLY AT PreventionGenetics?		BONE MARROW TRANSPLANT <input type="checkbox"/> NO <input type="checkbox"/> Yes, include date			
<input type="checkbox"/> NO <input type="checkbox"/> YES, PG ID# _____		MM/DD/YYYY		MM/DD/YYYY	
		TYPE			

### ELIGIBILITY CRITERIA

For individuals that meet the eligibility criteria below and wish to receive the program-specific genetic testing.

**REQUIRED: You must select below the appropriate eligibility criteria for this patient. Patient must be age 18 or older.**

**Patients with AT LEAST ONE hATTR high index of suspicion indicators (below) are eligible for testing. Check all that apply:**

- ☐ Family history of hATTR amyloidosis  
☐ Positive imaging consistent with amyloid (technetium, CMR, strain echo)  
☐ Positive biopsy for TTR amyloid

**OR**

**Patients with AT LEAST TWO hATTR index of suspicion indicators (below) are eligible for testing. Check all that apply:**

- ☐ Sensory and/or motor neuropathy (e.g., neuropathic pain, altered sensation, numbness and tingling, muscle weakness, impaired balance, difficulty walking, carpal tunnel syndrome-associated neuropathy, EMG/NCS abnormalities)  
☐ Autonomic dysfunction (e.g., nausea and vomiting, changes in GI motility, orthostatic hypotension, sexual dysfunction, bladder dysfunction)  
☐ Heart disease (e.g., cardiomyopathy, restrictive physiology, hypertrophy, arrhythmias, conduction abnormalities, heart failure, abnormal cardiac imaging)  
☐ Musculoskeletal indicators (e.g., history of carpal tunnel syndrome, back pain/lumbar spinal stenosis, rotator cuff injury)  
☐ Renal abnormalities (e.g., renal insufficiency and/or proteinuria)  
☐ Ocular changes (e.g., vitreous opacity, glaucoma, dry eyes, ocular amyloid angiopathy, retinal detachment)

### CLINICAL HISTORY

#### Family History

Is there a family history of the disease for which the patient is being tested? ☐ Yes ☐ No If yes, describe below and attach pedigree and/or clinical notes.

RELATIONSHIP TO PATIENT	SELECT	DIAGNOSED CONDITION	AGE AT DIAGNOSIS
	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal		
	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal		

#### Personal History

Is/was this patient affected or symptomatic?\* ☐ Yes ☐ No  
Provide details in the required clinical history questions (if applicable).

\* Symptomatic means this patient has features or signs known or suspected to be related to the genetic testing being ordered and could include findings on physical examination, laboratory tests, or imaging.

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## SP317 - Alnylam Act® hATTR Amyloidosis

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HAS PATIENT BEEN TESTED PREVIOUSLY AT PreventionGenetics?		MM/DD/YYYY		MM/DD/YYYY	
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**TEST SELECTION**

TEST CODE	TEST NAME	DESCRIPTION	SPECIAL INSTRUCTIONS
<input type="checkbox"/> 15139	<b>TTR (hATTR Amyloidosis) Single-Gene Analysis</b>	<i>TTR gene</i>	<b>SP317</b>
COMMENTS			<input type="checkbox"/> <b>SPECIMEN COLLECTED IN NEW YORK STATE</b> Include New York State 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.

**GENETIC COUNSELING**

Alnylam Pharmaceuticals has partnered with a third-party, Genome Medical, to provide no-cost genetic counseling services to any patient who enrolls in this sponsored testing program. Genome Medical will not disclose any protected health information to any party, including Alnylam Pharmaceuticals, as part of these services. By ordering this test, you are providing PreventionGenetics permission to facilitate the provision of genetic counseling services.

By checking the following boxes, my patient has agreed to allow PreventionGenetics to facilitate the provision of pre-test and/or post-test genetic counseling services by Genome Medical.

☐ **Pre-test** genetic counseling referral to Genome Medical.

☐ **Post-test** genetic counseling referral to Genome Medical.\*

\*Patients with positive or VUS results will be offered individual genetic counseling. Patients with negative results will be provided with genetic education via a video link.

**Genome Medical will contact the patient to schedule their genetic counseling appointment using the phone number and email address provided below.**

**Email or Phone AND State/Province must be provided for Genetic Counseling.**

PATIENT PHONE NUMBER

PATIENT EMAIL ADDRESS

STATE/PROVINCE WHERE PATIENT RESIDES (REQUIRED)

**Patients will receive a text message to schedule an appointment if they have SMS texting available on their phone.**

If Power of Attorney for medical decisions/communication is needed, the patient/family will need to provide documentation to Genome Medical upon scheduling their genetic counseling appointment.

For other questions related to genetic counseling, Genome Medical can be reached at: [clinical@genomemedical.com](mailto:clinical@genomemedical.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 in accordance with applicable laws/regulations, including state genetic testing laws, 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 attest that the patient meets the eligibility criteria for the Alnylam Act® program, that the genetic testing is clinically appropriate for the patient, and that you are authorized under applicable state/provincial law to order this test. You warrant that you will not seek reimbursement for this sponsored test from any third party, including but not limited to U.S. federal healthcare programs. You also 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 Alnylam Pharmaceuticals. No protected health information will be shared. For orders originating in Canada, the patient has been informed that their personal information and specimen will be transferred to and processed in the U.S. As the Healthcare Provider, you hereby authorize PreventionGenetics to share your name, institution, address, and contact information with Alnylam Pharmaceuticals, and consent to Alnylam Pharmaceuticals contacting you. For information about how Alnylam may use your personal data, visit <https://alnylampolicies.com/privacy> and view Privacy Notice for Healthcare Professionals (General Use). In addition, per applicable law, you may have the right to opt-out of certain uses of your data, and additional rights as detailed in PreventionGenetics privacy policy.

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.***

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#	PHONE NUMBER	NPI#	

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

**ALNYLAM10317**

SPECIAL PROJECT  
NUMBER

**SP317**

**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.

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: 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 accommodate. 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 SP317**