GENETIC TESTING PROGRAM REQUISITION FORM

NOVODETECT™
Driving change in the diagnostic journey
(FAMILIAL VARIANT TESTING)

200 Forest St, 2nd Fl
Marlborough, MA 01752, USA
Phone (US): 1.650.452.9340
Phone (CAN): 1.833.697.4665
Fax: 1.650.446.7790
support.us@blueprintgenetics.com (US)
support.ca@blueprintgenetics.com (CAN)

Blueprint Genetics
Keilaranta 16 A-B
02150 Espoo, Finland
Phone: 358.40.251.1372
Fax: 358.98.565.7177
support@blueprintgenetics.com

See test codes and detailed descriptions on tests on **blueprintgenetics.com**

REQUIRED FIELDS ARE MARKED WITH AN ASTERISK (*)

***TEST CODE** | F | V | T | 0 | 0 | 1 |

Promotion/Contract Code: NOVODETECT

TEST INFORMATION

*** Test Name:** NOVODETECT™ FAMILIAL VARIANT TESTING

All tests include analysis of both small exonic and splice site variations, and large deletions and insertions.

Sample type[i]: ☐ Blood ☐ Saliva ☐ DNA, source:	**Sample Collection Date:**

More information about sample requirements on blueprintgenetics.com/sample-requirements.

PROGRAM-SPECIFIC INFORMATION

Eligibility Criteria
Must meet the following:

Adult /Pediatric

- A family member participating in the NovoDetect program has received a genetic test result with pathogenic, likely pathogenic or variant of uncertain significance in one of the genes *AGXT*, *GRHPR* or *HOGA1*

ORDERING HEALTHCARE PROFESSIONAL INFORMATION

***Name:**		***Institution:**
***Street Address:**		***Email:**
***City:**	**State:**	***Phone:**
***Zip/Post Code:**	***Country:**	***Fax:**

Delivery of results ☐ **Mail** ☐ **Fax** ☑ **Nucleus** Results will always be available on our online reporting system at nucleus.blueprintgenetics.com.

SHARE RESULTS WITH A COLLEAGUE

Name:		**Role/Title:**	
Email:		**Street Address:**	
City:	**State:**	**Zip/Post Code:**	**Country:**
Phone:	**Fax:**	☐ **Mail Results** ☐ **Fax Results** ☐ **Nucleus**	Results can be shared within the same hospital on our ordering portal, Nucleus.

PATIENT INFORMATION

To enable processing, provide at least 2 unique patient identifiers that match those on the sample label (we recommend using the patient's full name: first & last name and date of birth).

*** First Name:**	*** Last Name:**
*** DOB: Year / Month / Day**	**Patient Identifier/MRN:**

PATIENT HISTORY

*** Sex:** ☐ Male ☐ Female ☐ Unknown/uncertain	**Ethnicity:**
*** Has the patient received a hematopoietic stem cell transplantation?** ☐ Yes ☐ No	
*** Has the patient received granulocyte transfusions in the past two weeks?** ☐ Yes ☐ No	

VARIANT SPECIFIC TESTING INFORMATION

FAMILIAL VARIANT TESTING

*** Indication for testing:**

☐ **Diagnostic** ☐ **Predictive** ☐ **Carrier** ☐ **Segregation** ☐ **Other:**

*** Was the index patient tested at Blueprint Genetics?**

☐ **Yes** ☐ **No / Not known**

*** Blueprint Genetics Order ID:**

*** Index Patient's Name:**

*** Index Patient's Date of Birth:**

*** Is the person being tested healthy and unaffected?**

If not, describe the clinical findings:

Clinical features of the individual and other relevant information for the geneticists:

*** Complete the following sentence to explain the relationship between the person being tested and the index patient.**

The person being tested is the index patient's: _____ (e.g. son, daughter, brother, sister, mother, father)

VARIANTS TO BE TESTED

	***Gene:** (e.g. LMNA)	***Transcript:** (e.g. NM_170707.3)	***cDNA change:** (e.g. c.4375C>T or c.612_615del)	***Protein change:** (e.g. Arg190Gln)
***Variant 1:**				
Variant 2:				
Variant 3:				
Variant 4:				
Variant 5:				
Variant 6:				
Variant 7:				
Variant 8:				
Variant 9:				
Variant 10:				

BILLING INFORMATION

☑ SPONSORED TESTING BILLING
Sponsor Name: Novo Nordisk

GENERAL TERMS

By placing the order the Customer accepts Blueprint Genetics' General Terms. Blueprint Genetics reserves the right to amend its General Terms, of which the latest version shall always be applied. The latest version can be found at https://blueprintgenetics.com/general-terms/

* ORDERING HEALTHCARE PROFESSIONAL SIGNATURE

Successful submission of this requisition form requires compliance with the following terms and conditions. My signature below indicates that I have read, understand, and agree to comply with the terms and conditions, as follows:

I have reviewed the content of the NovoDETECT™ Sponsored Genetic Testing Informed Consent with the patient or their authorized representative, including the notification that Blueprint Genetics may provide de-identified patient information to the sponsor of this testing program.

I confirm that I understand my patient's sample analysis will only begin when:
- Informed consent has been obtained in accordance with applicate state, federal, and/or country laws and regulations; and
- I have submitted this requisition successfully

To ensure compliance with state law, confirmation of informed consent is required for genetic testing. Testing laboratories in Massachusetts require acknowledgement from the ordering healthcare provider relating to this consent. This acknowledgment is required to complete the genetic testing ordered: I acknowledge that prior to ordering the genetic testing on the patient listed above, I have reviewed the written consent with the patient (or their authorized representative) as required by applicable state law and/or regulations, including that Blueprint Genetics may provide de-identified patient information to the sponsor of the Genetic Testing Program. I further understand a written informed consent is contained within the sample collection kit for the patient and this must be returned signed in order for the testing to be completed. I am able to obtain a copy of the informed consent from Blueprint Genetics if needed.

I agree I will not bill the patient or their insurance for the genetic counseling or the genetic testing services offered as part of the Program. I have read and understood the General Terms of Service. I authorize Blueprint Genetics and Program sponsor and their affiliates to contact me by mail, email or phone to inform me about ongoing clinical trials, clinical studies, services, and products that relate to the patients who have received a genetic test under this Program. I understand I may revoke this authorization by contacting Blueprint Genetics Client Services at 833-472-2999 and that by revoking authorization I will not be able to participate in the Program.

*** Signature:**	
*** Name:**	*** Date (YYYY-MM-DD):**

HEALTHCARE PROFESSIONAL SIGNATURE REQUIRED FOR PROCESSING