INVITAE

FATTY ACID OXIDATION DISORDER
Canada

ORDER ID
For Invitae internal use only

Requisition Form
LC-FAOD Sponsored Testing Program TRF887-3

This requisition form can be used to submit an order for the **Long-Chain Fatty Acid Oxidation Disorders Program**, a sponsored testing program for genetic disorders brought to you by **Ultragenyx Canada Inc.**

INSTRUCTIONS: Review the ordering options and then complete all sections of this form. Your ordering option will be indicated in the test selection section.

ORDERING OPTIONS

1. LC-FAOD SPONSORED TESTING PROGRAM

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

REQUIRED: You must select below the appropriate eligibility criteria for this patient.

This program is available to patients in Canada who meet at least one of the following criteria:

◯ The patient has completed the UltraCare® Enrolment Form for LC-FAOD (If available, please provide a copy of abnormal biochemical confirmatory labs)

OR

◯ Patient is suspected of having, or has been diagnosed with a long-chain fatty acid oxidation disorder **(check at least one) AND** a plasma acylcarnitine test has either been performed (regardless of result - abnormal or normal) or has been ordered.

- ◯ Carnitine palmitoyltransferase (CPT) IA deficiency
- ◯ Carnitine-acylcarnitine translocase (CACT) deficiency/ Carnitine palmitoyltransferase (CPT) II deficiency
- ◯ Long-chain 3-hydroxyacyl-CoA dehydrogenase (LCHAD) deficiency/Mitochondrial trifunctional protein (TFP) deficiency
- ◯ Very long-chain acyl-CoA dehydrogenase (VLCAD) deficiency

2. GENE-SPECIFIC FAMILY FOLLOW-UP TESTING

For relatives of program participants who received a Pathogenic/Likely Pathogenic result or approved VUS who want to receive gene specific family follow-up testing at no additional charge. Relatives do not need to meet the eligibility criteria listed above. Learn more at www.invitae.com/family.

PATIENT INFORMATION

First name	MI	Last name

Date of birth (MM/DD/YYYY)	Biological sex ◯ M ◯ F	MRN (medical record number)

Ancestry ◯ Asian ◯ Black/African American ◯ White/Caucasian ◯ Ashkenazi Jewish ◯ Hispanic ◯ Native American ◯ Pacific Islander ◯ French Canadian ◯ Sephardic Jewish ◯ Mediterranean ◯ Other: _____ ◯ Indigenous

Phone	Email address (report access after clinician releases)

Address	City

State/Prov	ZIP/Postal code	Country

Ship a kit to this patient (optional) by faxing or emailing this completed form to Invitae

Kit type: ◯ Buccal swab kit ◯ Saliva kit

Ship to: ◯ Address above ◯ Alternate address: _____

_____

SPECIMEN INFORMATION

Specimen type: Blood (3-mL purple EDTA) -OR- Buccal Swabs (OCD-100, 2 devices) -OR- Saliva (Oragene™) -OR- DNA source: _____

We are unable to accept blood/buccal/saliva from patients with:
- *Allogeneic bone marrow transplants*
- *Blood transfusion <2 weeks prior to specimen collection*

Specimen collection date (MM/DD/YYYY):
If not provided, the day before specimen receipt will be used

Special cases: ◯ History of/current hematologic malignancy in patient

INVITAE PARTNER CODE

FAOD C , A *(write in country code, two characters)*

CLINICIAN INFORMATION

Organization name	

Phone	Fax

Address	City

State/Prov	ZIP/Postal code	Country

Primary clinical contact name (if different from ordering provider)	NPI (US only)

Primary clinical contact email address (for report access)

Ordering provider (select one ordering provider by marking the checkbox before the name)

	Name	NPI (US only)	Email address (for report access)
◯			
◯			
◯			
◯			
◯			
◯			

Additional clinical or laboratory contacts (optional, to share access to order online)

◯ **Share this order with the primary clinical contact's default clinical team, manage at invitae.com**

Name	Email address (report access)
Name	Email address (report access)

CLINICAL HISTORY

FAMILY HISTORY

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

Relative's relationship to this patient	Maternal or paternal	Diagnosed condition	Age at diagnosis	Relative's relationship to this patient	Maternal or paternal	Diagnosed condition	Age at diagnosis

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.

REQUIRED CLINICAL HISTORY

Outcome of Newborn Screen (NBS)

◯ Positive – Suspected disorder: _____
◯ Negative
◯ Unknown

Outcome of confirmatory testing (e.g. acylcarnitine test)

◯ Positive – Disorder: _____
◯ Inconclusive – Disorder(s): _____
◯ Negative

If confirmatory test was positive, what is the reason for conducting this genetic test? (check all that apply)

◯ Payer requirement
◯ Differential diagnosis (between LC-FAOD types)
◯ Distinguish affected versus carrier status
◯ Understand disease course/prognosis
◯ Inform treatment decision
◯ Genetic counseling
◯ Identify at-risk family members
◯ Research
◯ Other: _____

Please provide a copy of the plasma acylcarnitine results. Providing a copy of plasma acylcarnitines results, or any other confirmatory tests, when available, is strongly encouraged. These results are helpful for variant interpretation and in some cases can make a difference for the final interpretation of the variant.

◯ Plasma acylcarnitine or confirmatory results attached
◯ Test results unavailable

What prompted you to suspect this patient may have a long-chain fatty acid oxidation disorder? (Exclude PHI)

Ongoing clinical features: (check all that apply)

◯ Cardiomyopathy
◯ Elevated creatine kinase
◯ Hepatomegaly
◯ Hypoketotic hypoglycemia
◯ Liver failure
◯ Muscle myopathy
◯ Myoglobinuria
◯ Peripheral neuropathy
◯ Reye like syndrome
◯ Rhabdomyolysis
◯ Retinitis pigmentosa
◯ Other: _____

OPTIONAL - REQUESTED VARIANTS FOR THIS PATIENT'S REPORT, IF KNOWN

To have the presence or absence of specific variants commented on in this patient's report, provide the details below. For gene-specific family follow-up see ***Note*** *under Test Selection.*

Was the proband (individual with variant) tested at Invitae? ◯ Yes, Invitae Order ID: RQ# _____ ◯ No: Attach copy of lab results (*required*)

Variant(s) *(e.g. GENE c.2200A>T (p.Thr734Ser) NM_00012345) If left blank, all variants identified in the proband will be commented on.*		**This patient's relationship to proband:**
		◯ Parent ◯ Sibling ◯ Grandchild
		◯ Child ◯ Self ◯ Other: _____

TEST SELECTION – Select test(s) from either option 1 or 2 below:

1. LC-FAOD SPONSORED TESTING PROGRAM – Indicate test(s) to be performed below:

Test code	Test name	# of genes	Gene list
◯ 06165	Invitae Fatty Acid Oxidation Defects Panel	25	ACAD9, ACADM, ACADS, ACADSB, ACADVL, CPT1A, CPT2, ETFA, ETFB, ETFDH, FLAD1, HADH, HADHA, HADHB, HMGCL, HMGCS2, MLYCD, NADK2, SLC22A5, SLC25A20, SLC25A32, SLC52A1, SLC52A2, SLC52A3, TANGO2

2. GENE-SPECIFIC FAMILY FOLLOW-UP TESTING *For relatives of a program participant ('proband') who received a Pathogenic/Likely Pathogenic result or approved VUS.*

◯ Family follow-up testing for Proband's Invitae Order ID: RQ#_____	**This patient's relationship to proband:** ◯ Parent ◯ Sibling ◯ Grandchild ◯ Child ◯ Other: _____	**Gene(s) to be tested in this patient:**

***NOTE**: The presence or absence of all variants identified in the proband for the gene(s) ordered for gene-specific family follow-up will be commented on in this patient's report unless a limited selection is specified in the **Requested Variants** section above. Invitae will report any Pathogenic/Likely Pathogenic variants found in this patient for the gene(s) ordered.*

Invitae continually updates its panels based on the most recent evidence. If an order is placed using an outdated test requisition form, Invitae reserves the right to upgrade ordered tests to their current versions. Test IDs containing add-on codes will include the original panel as well as the add-on.

By signing this form, the medical professional acknowledges that the individual/family member authorized to make decisions for the individual (collectively, the "Patient") has been supplied information regarding and consented to undergo genetic testing, and has reviewed and signed Invitae's Patient Consent for Sponsored Genetic Testing (International) (www.invitae.com/forms). The medical professional will retain this signed Consent and will provide it to Invitae upon request. In connection with the Program, the Patient has been informed that Invitae may notify the Patient of clinical updates related to genetic test results (in consultation with the ordering medical professional as indicated). The medical professional warrants that he/she will not seek reimbursement for this no-charge test from any third party, including but not limited to federal healthcare programs. The medical professional also hereby acknowledges that organization and clinician contact information provided in the order may be shared with third party sponsors of the Program, and that such third parties that may contact the medical professional directly in connection with the Program. The medical professional is under no obligation to order or recommend any products that may be made available by third party sponsors. The medical professional further acknowledges that he/she has made the Patient aware that third party sponsors of the Program may contact the Patient's medical professional regarding de-identified information gathered through the Program. The Patient has been informed that his/her personal information and specimen will be transferred to and processed in the United States, where local laws may require the disclosure of personal information to the government authorities under circumstances that are different than those that apply in Canada, and that de-identified Patient data may be used and shared for research purposes in the United States. In addition to the above, I attest that I am authorized under applicable law to order this test.

Medical professional signature (required)	**Date (MM/DD/YYYY)**

