Variantyx Genomic Unity® Targeted Analyses Test Requisition Form

Patient Name | Date of Birth | Affix barcode label of Patient's sample here

Required Information Checklist:

- ❍ Patient demographics
- ❍ ICD-10 codes
- ❍ Healthcare provider signature
- ❍ Signed informed consents
- ❍ Clinical & genetic counseling notes with pedigree (please include all family history of known chronic and inherited disease and copies of genetic test results, if available)
- ❍ Completed TRF and all clinical notes faxed to 617-433-5024
- ❍ Letter of medical necessity and/or required insurance forms if applicable

*Missing or insufficient information will cause a delay in pre-authorization and results.

Clinical Information

ICD-10 Code(s)*	Indication for testing
Suspected Diagnosis	Has this patient received counseling from a board certified genetic counselor? Yes /No
Are the clinical symptoms onset before the age of 21? Yes / No	Is the patient symptomatic? Yes / No
Are there ongoing pregnancies in the family? Yes / No	Has the patient had previous genetic testing? Yes / No *If yes please include copies of the reports.*

Please list previously reported variants here:

Targeted Analyses

Genomic Unity® Neurology testing options

- ❍ Genome-wide CNV and FMR1 Analysis (NR011)
- ❍ Epilepsy Analysis (NR004)
- ❍ Comprehensive Mitochondrial Disorders Analysis (MD001) **provides full mitochondrial genome analysis and germline genes related to mitochondrial disorders*
- ❍ Comprehensive Ataxia Analysis (NR002)
- ❍ Muscular Dystrophy Analysis (NR008)
- ❍ X- linked Intellectual Disability Plus Analysis (NR012)
- ❍ Ataxia Repeat Expansion Analysis (NR003)
- ❍ Movement Disorders Analysis (NR006)
- ❍ Neuropathies Analysis (NR009)
- ❍ Motor Neuron Disorders Analysis (NR005)
- ❍ Neuromuscular Disorders Analysis (NR007)
- ❍ Muscular Dystrophy Analysis (NR008)
- ❍ Dementia Analysis (NR010)
- ❍ Renal Analysis (UO001)
- ❍ Retinal Analysis (UO002)
- ❍ Hearing Loss Analysis (UO003)
- ❍ DMD Analysis (UO005)

Other Genomic Unity testing options:

- ❍ Constitutional Genome-Wide Copy Number Variant Analysis (CP004)
- ❍ Endocrinology Analysis (EA001)

Genomic Unity® Mitochondrial testing options:

- ❍ Mitochondrial Genome Sequence Analysis (MD002)
- ❍ Mitochondrial Genome Deletions Analysis (MD003)
- ❍ Nuclear Encoded Mitochondrial Gene Analysis(MD004)

Other Targeted Analyses:

Select from additional analyses offered online at
www.variantyx.com/products-services/rare-disorder-genetics/
Test Code: Test Name:

Stepwise Optional Reflex:

If the targeted analysis selected does not yield a diagnostic result, select one of the following:

❍ Reflex to Genomic Unity® Exome Analysis (CP002) ❍ Reflex to Genomic Unity® Exome Plus Analysis (CP010)
❍ Singleton ❍ Duo ❍ Trio

If the above reflex option is selected, you may opt to:

- ❍ Receive ACMG Secondary Findings only **No selection will default to opt-out.*
- ❍ Receive ACMG Secondary Findings with other actionable findings **No selection will default to opt-out.*
- ❍ Receive Genomic Unity® Pharmacogenomics Analysis **No selection will default to opt-out.*

❍ If the Genomic Unity® Exome Analysis or Genomic Unity® Exome Plus Analysis does not yield a diagnostic result, reflex to Genomic Unity® Whole Genome Analysis (CP001).
❍ If the test above does not yield a diagnostic result, reflex to Genomic Unity® 2.0 (DS001). **Reflex to CP001 or DS001 might not be covered by insurance.*

Healthcare Provider's Statement

By my signature below, I attest that I am the referring physician, an authorized healthcare provider for the patient or procurator thereof, and this testing is medically necessary for diagnosis and/or treatment of the patient. I attest that the patient or guardian has voluntarily consented to genetic testing for diagnostic purposes, including possible results and outcomes, ACMG secondary findings, and pharmacogenomics analysis, if selected, has been given the opportunity to ask questions about the testing and/or seek genetic counseling, and agrees to allow an independent genetic counselor facilitated through a third party to provide pre-test and/or post-test genetic counseling if required by the insurer and/or referring institution.

Healthcare provider signature _____ Date _____

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Patient Information

First Name	Last Name	MI	DOB	Genetic Sex
				❍ Male ❍ Female ❍ Other _____ Gender identification (optional):

Address	ID / MR#

City	State	Zip Code	Phone	Email

Other Name (if different than listed above): ❍ Please use this name in communications.	Pronouns	Preffered language ❍ English ❍ Spanish

Comparator Information

First Name	Last Name	DOB	Relationship to proband	Genetic Sex
				❍ Male ❍ Female ❍ Other _____ Gender identification (optional):

If affected by the same disorder as the patient please list the clinical symptoms

Address	Phone	Email

Comparator Information

First Name	Last Name	DOB	Relationship to proband	Genetic Sex
				❍ Male ❍ Female ❍ Other _____ Gender identification (optional):

If affected by the same disorder as the patient please list the clinical symptoms

Address	Phone	Email

Ordering Healthcare Provider

First Name	Last Name	Phone	NPI #

Facility Name	Facility Address	City

City	Zip Code	Email	Fax

Additional Report Recipients

Name	Phone	Fax	Email
Name	Phone	Fax	Email
Add GC or other healthcare provider(s)?			

Billing Information

○ Insurance billing	Insurance Company	Policy #	Group #

Policy holder first name	Policy holder Last name	Policy Holder DOB	Who is the Policy Holder? ❍ Patient ❍ Spouse ❍ Parent

Address	Employer's Address

○ Institutional billing	❍ Patient Payment *An invoice will be sent to the patient email provided. Insurance will not be billed.*

An invoice will be sent to the institution listed above. Please contact us for alternate billing.	Who should be contacted for billing purposes? Payer Name: Payer Phone: Payer Email:

Patient Sample Information

Sample Type ❍ Saliva* ❍ Saliva swab*† ❍ Assisted saliva* ❍ Blood ❍ Genomic DNA ❍ Other *Use Variantyx collection kits only † Saliva swab may have reduced sensitivity and specificity due to the presence of normal oral flora	Sample Will Be Collected ❍ In-clinic ❍ Patient was given kit ❍ By Variantyx

Please check if your patient has had a: ❍ Blood transfusion within the last two weeks ❍ Bone marrow transplant *We will contact you for additional specimen collection details.*	Collection date

*Please note that the newest version of the assay will be selected by default.