GENETIC TESTING PROGRAM REQUISITION FORM

Discover Dysplasias™
No-Charge Genetic Test for Skeletal Dysplasias

Blueprint Genetics

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Promotion/Contract Code: **BMRN-DD**

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

REQUIRED FIELDS ARE MARKED WITH AN ASTERISK (*)

***TEST CODE** | F | O | P | 2 | 1 | 0 | 9 |

TEST INFORMATION

*** Test Name:** FLEX Comprehensive Skeletal Dysplasias and Disorders Panel

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:**

i) Please note that this information affects interpretation for mitochondrial DNA testing.
More information about sample requirements on blueprintgenetics.com/sample-requirements.

PROGRAM-SPECIFIC INFORMATION

***Eligibility Criteria**

Select at least one finding that affects your patient:

- ☐ Signs or symptoms suggestive of skeletal dysplasia
- ☐ Disproportionate growth
- ☐ Dysmorphic facial features
- ☐ Abnormal gait with joint pain

Additional genes:

The panel in this program is an enhanced version of the Comprehensive Skeletal Dysplasias and Disorders Panel. For additional information, including the list of added genes, please visit www.blueprintgenetics.com/discover-dysplasias

ORDERING HEALTH CARE PROFESSIONAL INFORMATION

*** Name and Full Address:**	*** Institution:**	
	*** Email:**	
	NPI# (REQUIRED, US only):	
	Phone:	**Fax:**

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

SHARE RESULTS WITH

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

*** First Name:**		*** Last Name:**	
*** DOB: Year / Month / Day**		**MRN/SSN:**	
Street Address:			
City:	**State:**	**Zip/Post Code:**	**Country:**
Phone:	**Email:**		

PATIENT HISTORY

*** Sex:** ☐ Male ☐ Female ☐ Unknown/ uncertain | **Ethnicity:** | **ICD-10 Codes:**

*** Indication for Testing:** ☑ Diagnostic ☐ Family History ☐ Other:

*** Has the Patient Received a Hematopoietic Stem Cell Transplantation?** ☐ Yes ☐ No

*** Has the Patient Received Granulocyte Transfusions in the Past Two Weeks?** ☐ Yes ☐ No

*** Describe the Relevant Clinical Findings Supporting the Diagnosis** (attach possible supportive material such as ECG):

- ☐ Short stature
- ☐ Macrocephaly
- ☐ Joint dislocations/hypermobility
- ☐ Joint contractures/stiffness
- ☐ Atlanto-axial instability
- ☐ Dysmorphic features
- ☐ Dysostosis multiplex
- ☐ Odontoid hypoplasia
- ☐ Acetabular dysplasia
- ☐ Coxa valga
- ☐ Genu valgum
- ☐ Developmental delay or learning disability
- ☐ Hepatomegaly
- ☐ Splenomegaly
- ☐ Frequent upper respiratory infections
- ☐ Carpal tunnel syndrome
- ☐ Problems with vision
- ☐ Problems with hearing
- ☐ Other skeletal abnormalities, specify:

Other Clinical Findings:

Family History (attach pedigree if available):	**Previous Genetic Testing Results:**

VARIANT SPECIFIC TESTING INFORMATION

REQUIRED FIELDS ARE MARKED WITH AN ASTERISK (*)

Please select either Familial Variant Testing or Targeted Variant Testing

☐ **Familial Variant Testing - Not applicable**	☐ **Targeted Variant Testing - Not applicable**
Index Patient's Order ID: **Index Patient's Subject ID:**	**Indication for testing:** ☐ **Confirmation of research results** ☐ **Clarifying interpretation** ☐ **Founder/common mutation** ☐ **Other:**
Indication for testing ☐ **Diagnostic** ☐ **Predictive** ☐ **Carrier** ☐ **Segregation** ☐ **Other:**	
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:				

* BILLING INFORMATION

☐ **INSTITUTIONAL BILLING**	
Facility Name: BioMarin International Limited, Accounts Payable	
Street Address: 5th Floor, 5 Earlsfort Terrace, Earlsfort Centre	**City:** Dublin **State:** **Zip/Post Code:** D02CK83
Country: Ireland	**Contact Person:** Paula Almeida
Phone: +44 207 420 3330	**Email:** paula.almeida@bmrn.com

PROGRAM TERMS

By placing the order the Customer accepts the terms and conditions of the Genetic Testing Program ("Program Terms"). Blueprint Genetics reserves the right to amend the Program Terms, of which the latest version shall always be applied. The latest version can be found at https://blueprintgenetics.com/discover-dysplasias.

ORDERING HEALTH CARE PROFESSIONAL SIGNATURE

I have discussed the General Form with the patient or their legal guardian and obtained any other consent from the patient that is required under the laws of my country/state and/or federal laws. I certify that the test ordered is medically necessary for the diagnosis or detection of a disease, illness, impairment, symptom, syndrome or disorder. The results of this test will be used in the medical management of the patient and/or genetic counseling of the patient and family member(s). I have read and understood the Program Terms. I understand that Blueprint Genetics will share my name and contact information with BioMarin Pharmaceuticals in accordance with the Genetic Testing Program Privacy Notice, as posted at https://blueprintgenetics.com/discover-dysplasias.

*** Signature:**	*** Date:**
*** Name:**	

HEALTH CARE PROFESSIONAL SIGNATURE REQUIRED FOR PROCESSING