GENETIC TESTING PROGRAM REQUISITION FORM

NOVODETECT™
Driving change in the diagnostic journey

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PLEASE SELECT **ONE** PANEL TO CONTINUE PROCESSING:

REQUIRED FIELDS ARE MARKED WITH AN ASTERISK (*)

☐ **NOVODETECT™ NEPHROLITHIASIS PANEL**
(45 Gene Panel)

***TEST CODE** K I 3 0 0 1

☐ **NOVODETECT™ PRIMARY HYPEROXALURIA (PH) PANEL**
(3 Gene Panel)

***TEST CODE** K I 2 9 0 1

This Program does not offer any other testing panel. Be sure to select the panel that is more appropriate for your patient.

In the event of a genetic variant of unknown significance in the *AGXT, GRHPR*, or *HOGA1* gene, I acknowledge and agree that I am ordering a PH Urine Metabolite Assay as part of this Program. My patient will be asked to submit a urine sample for further metabolite testing. My patient will be contacted to provide the urine sample through ExamOne services. ExamOne, like Blueprint Genetics, is a Quest Diagnostics company.

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**
Must meet 1 or more of the following:
Adult /Pediatric
- Family history of recurrent kidney stones and/or monogenic disorders, including Primary Hyperoxaluria, resulting in recurrent kidney stones
- Previous genetic testing with a variant of uncertain significance reported in *AGXT, GRHPR* or *HOGA1*
- Laboratory indication (urine/blood biochemistry or stone analysis composition) of monogenic disorders resulting in recurrent kidney stones (i.e., elevated oxalate in urine, plasma, or oxalate within stone analysis)
- Advanced chronic kidney disease of unknown etiology
- Clinical diagnosis of nephrocalcinosis
- Kidney stones:
  - *Adults (18 years of age and older)* with history or presence of bilateral/ multiple/recurrent kidney stones
  - *Pediatrics (<18 years of age)* with history or presence of 1 or more kidney stones

Pediatric
- Children (<2 years old) with failure to thrive AND impaired renal function

☐ I attest my patient meets the eligibility criteria for the Program

Pre- and post- result genetic counseling is offered for all patients undergoing genetic testing through the Program.
Please check the box(es) to indicate genetic counseling preference(s) below:**

☐ I request pre-result genetic counseling for this patient through Quest Diagnostics Laboratories

☐ I request post-result genetic counseling for this patient through Quest Diagnostics Laboratories

** I understand that if I do not opt-in for Quest Diagnostics genetic counseling services, I will provide genetic counseling to the patient or refer the patient to local genetic counseling services. With this option I understand the cost of genetic counseling is not covered by NovoDetect. I affirm my patient understands the options available, and understands and accepts the additional costs that may be incurred in selecting this option.

ORDERING HEALTHCARE PROFESSIONAL INFORMATION

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

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

In the event of a genetic variant of unknown significance in the *AGXT*, *GRHPR*, or *HOGA1* gene, PH Urine Metabolite Test Result will be delivered by fax.

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.

REQUIRED FIELDS ARE MARKED WITH AN ASTERISK (*)

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:**
*** Phone:**	*** State of Residence:**

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

*** Indication for testing:** ☐ Diagnosis ☐ Family History ☐ Other:

Affected family members: ☐ Yes ☐ No
Who and what symptoms?

Previous genetic tests: ☐ Yes ☐ No
Specify test and results:

*** Describe the most relevant clinical findings supporting the diagnosis** (attach possible supportive material):

BILLING INFORMATION

☑ **SPONSORED TESTING BILLING**

Facility 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. Please check the following boxes to demonstrate compliance:

☐ 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