Ambry Genetics® A TEMPUS COMPANY | MISSION: GENOME by Rocket Pharma

Test Requisition Form

COMPLETE ENTIRE FORM AND SUBMIT PEDIGREE/CLINIC NOTES TO AVOID DELAYS

To submit an order via email, please send the completed test requisition form to info@ambrygen.com

Project code: PHRROC 150900 Rocket Pharmaceuticals PIP

PATIENT INFORMATION

Legal Name (Last, First, MI)	Date of Birth (MM/DD/YY)	Sex Assigned at Birth ☐F ☐M	Gender (optional) ☐Man ☐Woman ☐Nonbinary ☐Self-described

Genetic Ancestry: ☐Ashkenazi Jewish ☐Asian ☐Black/African American ☐French Canadian/Cajun ☐Hispanic/Latino ☐Mediterranean ☐Middle Eastern ☐Native American ☐Pacific Islander ☐Portuguese ☐White ☐Unknown ☐Other:

Address	City	State	Zip

Phone	Email

Guardian Name	Patient/Guardian Phone	Patient/Guardian Email

SPECIMEN INFORMATION*

Sample Type: ☐Saliva Collection Assistance: ☐Send Saliva Kit to Patient ☐Personal history of allogenic bone marrow or peripheral stem cell transplant*

Collection Date If date of collection is not provided, three calendar days before specimen receipt will be used (for specimens stored longer than 30 days, the day of archive retrieval will be used as the date of service)	Specimen ID	Medical Record #

** Saliva from patients with a history of allogenic bone marrow or stem cell transplant cannot be used for genetic testing. Saliva from patients with active hematological disease is not recommended. An alternative specimen may be needed. Please see ambrygen.com/specimen-requirements for details.*

BILLING FACILITY

Rocket Pharmaceuticals PIP SOW1 (44556)

ORDERING PHYSICIAN/SENDING FACILITY (Each listed person will receive a copy of the report)

Facility Name (Facility Code)	Address	City	State /Country	Zip	Phone

Ordering Licensed Provider Name (Last, First)(Code)	NPI#	Phone	Fax/Email

Additional Results Recipients

Genetic Counselor or Other Medical Provider Name (Last, First) (Code)	Phone/Fax/Email

PATIENT ELIGIBILITY: To qualify for the testing program, the patient must be from the United States and be under 40 years of age at the time of testing with a high suspicion of an inherited cardiomyopathy.

Patient Eligibility Checklist: Please confirm patient age and select at least one YELLOW box to qualify patient for the testing program.

Age Requirement	Clinical Requirement (select at least one box)
☐ Patient is under 40 years of age	☐ Patient has a diagnosis of cardiomyopathy (excluding acquired causes, i.e. medical induced, viral infection, etc.)
	☐ Family history of Danon Disease

Check to Order	Test Name	Test Code	# of Genes	Gene List
☐	CardioNext®	8911	92	*ABCC9, ACTC1,ACTN2, AKAP9, ALMS1, ALPK3, ANK2, ANKRD1, BAG3, CACNA1C, CACNA2D1, CACNB2, CALM1, CALM2, CALM3, CASQ2, CAV3, CRYAB, CSRP3, DES, DMD, DOLK, DSC2, DSG2, DSP, EMD, EYA4, FHL1, FKRP, FKTN, FLNC, GATAD1, GLA, GPD1L, HCN4, JPH2, JUP, KCND3, KCNE1, KCNE2, KCNE3, KCNH2, KCNJ2, KCNJ5, KCNJ8, KCNQ1, LAMA4, LAMP2, LDB3, LMNA, MYBPC3, MYH6, MYH7, MYL2,MYL3, MYOZ2, MYPN, NEXN, NKX2-5, PKP2, PLN, PRKAG2, PTPN11, RAF1, RBM20, RIT1, RYR2, SCN10A, SCN1B, SCN2B, SCN3B, SCN4B, SCN5A, SNTA1, SOS1, TAZ, TBX20, TBX5, TCAP, TECRL, TGFB3, TMEM43, TNNC1, TNNI3, TNNT2, TPM1, TRDN, TRPM4, TTN, TTR, TXNRD2, VCL*

If you are ordering testing for a patient who has a family member with a known mutation, please use Ambry's Specific Site Analysis (SSA) test requisition form, found here: ambrygen.com/providers/forms

CONFIRMATION OF INFORMED CONSENT AND MEDICAL NECESSITY FOR GENETIC TESTING

The undersigned person (or representative thereof) ensures he/she is a licensed medical professional authorized to order genetic testing and confirms that the patient has given appropriate informed consent for genetic testing. I confirm testing is medically necessary, and test results may impact medical management for the patient. All information on this ordering form is true to the best of my knowledge. I have informed the patient that Ambry Genetics may notify me, the ordering medical professional, of clinical updates related to genetic test results. I warrant that I will not seek reimbursement for this sponsored test from any third party, including but not limited to U.S. federal healthcare programs. I understand that the use of this sponsored test is not intended to be, nor should it be construed as, either express or implied, an obligation or inducement for me to recommend, purchase, order, prescribe, promote, administer or otherwise support any Rocket Pharmaceuticals product or any other Ambry Genetics product or service.

☐ For NY Residents: I understand that New York State law requires Ambry Genetics to destroy my sample at the end of the testing process or not more than sixty days after the sample was taken. By checking this box, I agree that Ambry Genetics will instead retain my sample for at least 6 months after the testing above has been completed, and may (a) retain and use samples and health information for an indefinite period of time in accordance with applicable law; and (b) de-identify such samples and information and use and share the resulting de-identified samples and information in accordance with applicable law.

Signature Required for Processing Medical Professional Signature: Date:

1 Enterprise, Aliso Viejo, CA 92656 USA Toll Free +1.866.262.7943 Fax +1.949.900.5501 **ambrygen.com**

MKT-PHAR-TRF-20027-EN v2 10.01.25