# Agios Clinical Genomics Requisition Form

This requisition form can be used to submit a specimen for the Anemia Identified program, a no-charge US testing program sponsored by Agios and offered through Revvity. All patients suspected of having, or with a family history of, Hereditary Anemia (HA) can take part in the Anemia Identified Program.

The Anemia Identified program facilitates access to genetic testing to help in the diagnosis of HA or carrier status identification of HA. While Agios provides financial support for this program, tests and services are performed by an independent third party, Revvity. Healthcare providers must confirm that patients meet certain criteria to use the program. Agios receives de-identified patient data from this program, but at no time does Agios receive patient identifiable information. Agios receives contact information for healthcare providers who use this program. Genetic testing is available in the U.S. and Puerto Rico only. Healthcare providers who use this program have no obligation to recommend, purchase, order, prescribe, promote, administer, use or support any Agios product.

Please complete every field and tick box clearly.

## STEP 1: PATIENT INFORMATION

Patient's First Name | Middle Initial | Patient's Last Name

MM/ DD /YYYY
Patient's Date of Birth | Patient ID/MR Number/External Sample Number

Biological Sex: ○ Male ○ Female ○ Unknown
Gender Identity (if different from above):_____

Patient's Street Address | City / Town

State | Zip Code | Country | Patient's Preferred Phone | Patient's Email

Ethnicity (check all that apply): ○ African-American ○ Asian (China, Japan, Korea) ○ Caucasian/N. European/S. European ○ Finnish ○ French Canadian ○ Hispanic ○ Jewish - Ashkenazi ○ Jewish - Sephardic ○ Mediterranean ○ Middle Eastern (Saudi Arabia, Qatar, Iraq, Turkey) ○ Native American ○ E. Indian ○ Southeast Asian (Vietnam, Cambodia, Thailand) ○ South Asian (India, Pakistan) ○ Other (specify)_____

## PATIENT SAMPLE INFORMATION

**SAMPLE TYPE:** ○ Saliva Swab ○ Whole Blood Collection Date: MM/DD/YY Was this sample collected in the State of NY, NV or OR? ○ Yes ○ No

## INDICATION FOR TESTING

○ Diagnosis in symptomatic patient ○ Carrier testing ○ Presymptomatic testing of at-risk family member ○ Other:_____

## STEP 2: ORDERING PROVIDER AND REPORTING PREFERENCE

Provider's First and Last Name | NPI

Clinic/Hospital/Institution Name | Provider's Email

Provider's Street Address | City / Town | State | Zip Code | Country

Provider's Phone | Provider's Fax

## SEND ADDITIONAL COPY OF RESULTS TO (If applicable)

Name | Email Address

Phone Number | Fax Number

## STEP 3: BILLING INFORMATION

☒ **INSTITUTIONAL BILLING**

**Agios** | **B0374**

Institution/Organization Name | Billing Account ID

**Do not bill patient's insurance.**

| FOR INTERNAL USE ONLY | | | | |
|---|---|---|---|---|
| Date Rec'd_____ Rec'd _____ | | | | |
| TEMP | SPEC | COL | #TUBES | VOL |
| R/C/F | | | | |
| R/C/F | | | | |
| R/C/F | | | | |

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## STEP 4: TEST MENU

○ AGS001 Hereditary Anemia Panel
○ AGS002 Pyruvate Kinase Enzyme Activity

| Test Ordered | Acceptable Sample | Cold Pack Needed? |
|---|---|---|
| Hereditary Anemia Panel | 1 Whole Blood (EDTA) sample or 1 saliva sample | NO |
| Pyruvate Kinase Enzyme Activity | 1 Whole Blood (EDTA) sample | YES* |
| Hereditary Anemia Panel and Pyruvate Kinase Enzyme Activity together | 2 Whole Blood (EDTA) samples | YES* |

* Follow the instructions included in the whole blood collection pack to ensure proper usage of the cold pack.

## STEP 5: PHYSICIAN CONFIRMATION OF INFORMED CONSENT AND MEDICAL NECESSITY

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 the testing ordered, including a discussion of the benefits and limitations. I confirm that testing is medically necessary and that test results may impact medical management for the patient. Furthermore, all information on this TRF is true to the best of my knowledge. My signature applies to the informed consent and/or attached letter of medical necessity.

I consent to Revvity sharing my name and contact information, and the date on which I executed this TRF, with Agios Pharmaceuticals and I understand and agree that I may be contacted by Agios Pharmaceuticals in connection with the genetic testing program for the purpose of receiving information on hereditary anemias, including pyruvate kinase deficiency.

Signature_____ Date_____

## ADDITIONAL OPTIONAL PHENOTYPE / PATIENT HISTORY SECTION

### Clinical History

**CBC Data**

WBC: _____
HGB: _____
HCT: _____
RBC: _____
MCV: _____
MCH: _____
CHC: _____
RDW: _____
PLT: _____
Rectics %: _____
Abs Retic: _____
Ferritin: _____

**Relevant Clinical Information**

○ Asymptomatic ○ Symptomatic: _____
○ Acquired ○ Lifelong/familial ○ Perinatal/neonatal ○ Chronic ○ Episodic/sporadic
Recent transfusion: ○ Yes ○ No Last transfusion date *(mm-dd-yyyy)*: _____
Family history: ○ Yes ○ No Disorder/relation to patient: _____
Parental consanguinuity: ○ Yes ○ No
Blood smear shows: _____
Bone marrow shows: _____

### Indication for Testing (See Metabolic Hematology Profile Comparison Chart)

**Suspect**

○ Hereditary spherocytosis
○ Hereditary elliptocytosis
○ Hereditary pyropoikilocytosis
○ Hereditary stomatocytosis
○ Pyruvate Kinase Deficiency
○ Southeast Asian ovalocytosis
○ Congenital dyserythropoietic anemia
○ Enzyme disorder: _____
○ Other: _____

**Previous Results**

Previous protein/functional testing: ○ Yes _____
Hb electrophoresis: _____

○ G6PD activity level: _____ Coombs: ○ Pos ○ Neg ○ Not Done
○ IK activity level: _____ Splenectomy: ○ Yes ○ No
○ Other enzyme level(s): _____
○ Osmotic fragility: ○ Normal ○ Increased ○ Decreased ○ Not performed
○ EMA binding/Band3: ○ Normal ○ Abnormal ○ Not performed
○ Ektacytometry: _____

250 Industry Drive, Pittsburgh, PA 15275
T 866-354-2910 • F 470-201-1321 • genomics@revvity.com