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ORDER ID
For internal use only

Requisition Form

Krystal Biotech - Decode DEB Program TRF1018-1

This requisition form can be used to submit an order for the **Decode DEB Program**, sponsored by **Krystal Biotech**.

INSTRUCTIONS: Review the eligibility criteria and then complete all sections of this form. Your ordering option will be indicated in the test selection section.

DECODE DEB PROGRAM ELIGIBILITY CRITERIA

DECODE DEB PROGRAM

For individuals that meet the eligibility criteria below and wish to receive the program specific genetic testing panels.

REQUIRED: You must select below the appropriate eligibility criteria for this patient.

This program is available to patients residing in the United States, including Puerto Rico, who meet the following eligibility requirement:

◯ Patient has clinical symptoms consistent with epidermolysis bullosa (EB)

PATIENT INFORMATION

First name	MI	Last name

Date of birth (MM/DD/YYYY)	Biological sex ◯ M ◯ F	MRN (medical record number)

Ancestry ◯ Asian ◯ Black/African American ◯ White/Caucasian ◯ Ashkenazi Jewish ◯ Hispanic ◯ Native American ◯ Pacific Islander ◯ French Canadian ◯ Sephardic Jewish ◯ Mediterranean ◯ Other: _____

Phone	Email address (report access after clinician releases)

Address	City

State/Prov	ZIP/Postal code	Country

Ship a kit to this patient (optional) by faxing or emailing this completed form to Labcorp Genetics

Kit type: ◯ Buccal swab kit ◯ Saliva kit

Ship to: ◯ Address above ◯ Alternate address: _____

SPECIMEN INFORMATION

Specimen type: Blood (3-mL purple EDTA) -OR- Buccal Swabs (OCD-100, 2 devices) -OR- Saliva (Oragene™) -OR- DNA source: _____

*We cannot accept blood or oral specimens from patients with active hematologic malignancy, recent leukocyte transfusion, or history of bone marrow/stem cell/liver transplants. DNA must be extracted in a CLIA or other suitably certified lab and cannot be from prenatal or tumor sources. Details at: **invitae.com/specimen-requirements***

Specimen collection date (MM/DD/YYYY): ☐☐ ☐☐ ☐☐☐☐

Special cases: ◯ History of/current hematologic malignancy in patient

PARTNER CODE DEB

CLINICIAN INFORMATION

Organization name	

Phone	Fax

Address	City

State/Prov	ZIP/Postal code	Country

Primary clinical contact name (if different from ordering provider)	NPI

Primary clinical contact email address (for report access)

Ordering provider (select one ordering provider by marking the checkbox before the name)

	Name	NPI	Email address (for report access)
◯			
◯			
◯			
◯			
◯			
◯			

Additional clinical or laboratory contacts (optional, to share access to order online)

◯ **Share this order with the primary clinical contact's default clinical team, manage at invitae.com**

Name	Email address (for report access)

Name	Email address (for report access)

CLINICAL HISTORY

FAMILY HISTORY

Is there a family history of disease for which the patient is being tested? ◯ Yes ◯ No If yes, describe below and attach pedigree and/or clinical notes.

Relative's relationship to this patient	Maternal or paternal	Diagnosed condition	Age at diagnosis	Relative's relationship to this patient	Maternal or paternal	Diagnosed condition	Age at diagnosis

OPTIONAL - REQUESTED VARIANTS FOR THIS PATIENT'S REPORT, IF KNOWN

To have the presence or absence of specific variants commented on in this patient's report, provide the details below. For gene-specific family follow-up see ***Note*** *under Test Selection.*

The proband's (individual with the variant) gene/variant information is needed for this request. Provide the Invitae Order ID RQ#: _____ **OR** attach a copy of the outside lab results *(required)*

Variant(s) *(e.g. GENE c.2200A>T (p.Thr734Ser) NM_00012345) If left blank, all variants identified in the proband will be commented on.*		**This patient's relationship to proband:**
		◯ Parent ◯ Sibling ◯ Grandchild
		◯ Child ◯ Self ◯ Other: _____

TEST SELECTION – Select test(s) from either option 1 or 2 below:

1. DECODE DEB PROGRAM – Indicate test(s) to be performed below:

Test code	Test name	# of genes	Gene list
◯ PTSTY5CP	Krystal Bio Custom DEB Panel	25	ATP2C1, CD151, CDSN, COL17A1, COL7A1, DSG1, DSP, DST, EXPH5, FERMT1, ITGA3, ITGA6, ITGB4, JUP, KLHL24, KRT1, KRT10, KRT14, KRT5, LAMA3, LAMB3, LAMC2, PKP1, PLEC, SERPINB8

2. GENE-SPECIFIC FAMILY FOLLOW-UP TESTING *For relatives of a program participant ('proband') who received a Pathogenic/Likely Pathogenic result or approved VUS.*

◯ Family follow-up testing for Proband's Invitae Order ID: RQ#_____	**This patient's relationship to proband:** ◯ Parent ◯ Sibling ◯ Grandchild ◯ Child ◯ Other: _____	**Gene(s) to be tested in this patient:**

NOTE*: The presence or absence of all variants identified in the proband for the gene(s) ordered for gene-specific family follow-up will be commented on in this patient's report unless a limited selection is specified in the* ***Requested Variants*** *section above. The laboratory will report any Pathogenic/Likely Pathogenic variants found in this patient for the gene(s) ordered.*

If an order is placed using an outdated test requisition form, we reserve the right to upgrade ordered tests to their current versions. Test IDs containing add-on codes will include the original panel as well as the add-on.

Invitae is now part of Labcorp. By signing this form, the medical professional acknowledges that the individual/family member authorized to make decisions for the individual (collectively, the "Patient") has been supplied information regarding and consented to undergo genetic testing, substantially as set forth in Labcorp Genetics' Informed Consent for Genetic Testing (invitae.com/forms). The medical professional will retain evidence that the patient consented to genetic testing. The Patient has been informed that Labcorp Genetics may notify them of clinical updates related to genetic test results (in consultation with the ordering medical professional as indicated) and has been informed that deidentified (also referred to as pseudonymized) patient data may be used and shared with third parties in connection with the Program, for research and commercial purposes. For orders originating outside the United States, the Patient has been informed that their personal information and specimen will be transferred to and processed in the United States. The medical professional warrants that (1) he/she will not seek reimbursement for this no-charge test from any third party, including but not limited to government healthcare programs; (2) participation in the Program will not influence his/her medical decisions; (3) he/she is not obligated to purchase or prescribe any product or service offered by a sponsor of the Program; (4) he/she is not obligated to participate in or to encourage patients to participate in any clinical trial or other research program conducted by a sponsor; and (5) he/she will participate in the Program in accordance with applicable laws. The medical professional consents to the sharing of organization and provider contact information with third parties, including commercial organizations, who may contact the medical professional directly in connection with the Program. Providers have data privacy rights as detailed in Labcorp Genetics' privacy policy. If I am a delegate, I confirm I have authorization to (1) agree to all of the above and (2) sign this form and any supporting documents for Labcorp Genetics on behalf of the ordering provider. A list of third party partners will be provided upon request. I attest that I am authorized under applicable law to order this test.

Medical professional signature (required)	**Date (MM/DD/YYYY)**