Arkana Laboratories

Physician Requisition Form for the No Cost to Patient *APOL1* Genotyping Program

Please complete every field.

Arkana Laboratories and Vertex are working together to make it possible to provide *APOL1*-risk variant testing at no cost to patients who meet four of the following criteria:

1) Self-report race as Black, African American, African, Afro-Caribbean, Hispanic, Latino, or other African ancestry
2) History of proteinuria or elevated serum Cr
3) Absence of diabetes mellitus
4) Absence of end stage kidney disease or kidney transplant

Specimen Information: ☐ Buccal Swab (included in kit) ☐ Kidney Biopsy Previously Processed at Arkana

Laboratory Test Values: 24 hour urine protein or urine prot:Cr _____ CKD Stage: _____ eGFR: _____

Self-reported race/ethnicity: Check all that apply

☐ Black/African American ☐ Afro-Caribbean ☐ African ☐ Hispanic ☐ Latino ☐ Other _____

Patient Information:

Patient Name: _____ Date of Birth (MMDDYYYY): _____ Gender: ☐ M ☐ F

Address: _____ City: _____ State: _____ Zip Code: _____

Phone #: _____ Email: _____ Medical Record #: _____

Referring Physician Information:

Name: _____ ☐ MD ☐ DO Phone #: _____ Fax #: _____

Institution: _____ Address: _____

City: _____ State: _____ Zip Code: _____ Email: _____

Professional Genetic Counseling

In order to derive the most meaningful benefit from this testing, it is recommended that the results be discussed with your healthcare provider or a trained genetics professional. For those enrolled in the free sponsored testing, a genetic counselor will reach out to deliver results to all patients who have two copies of APOL1 risk alleles and are therefore at increased risk of APOL1-mediated kidney disease.

Arkana Laboratories Agreement for *APOL1* Sponsored Testing

By requesting testing from Arkana Laboratories, the ordering physician indicates that they understand and agree with the following.

A. Should required information not be provided in the test requisition form, lab personnel may contact the clinical office or patient directly to obtain or verify information required to complete the form.
B. Results will only be released to the providers listed on the requisition form and a genetics counselor (if requested).
C. It is the responsibility of the ordering physician to disclose test results and direct the patient's care as appropriate.
D. The ordering provider's name and institution name may be shared with Vertex Pharmaceuticals to track test utilization.
E. The patient fulfills criteria for no cost testing by fulfilling all four criteria listed at the top of this form and the test is clinically appropriate for the patient.
F. A genetic counselor will reach out to discuss results with patients who have two risk alleles (if requested) via Metis Genetics at no cost to the patient.
G. The patient has been informed that Arkana may de-identify information obtained from the test and share that information with Vertex Pharmaceuticals.

Ordering Provider Signature

I, _____ (Print Name), as ordering physician, certify that the patient being tested and/or their legal guardian have been informed of the risks, benefits, and limitations of the testing ordered, as well as the policies of Arkana Laboratories listed above. I have obtained informed consent, as required by my own state and/or federal laws. In addition, I assume responsibility for returning the results of genetic testing to my patient and/or their legal guardian.

_____ _____

Signature (Ordering Physician) Date

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