HEREDITARY NEUROPATHY PANEL SPONSORED BY TAYSHA GENE THERAPIES TEST REQUISITION FORM

TAYSHA GENE THERAPIES GeneDx

PATIENT INFORMATION

First Name*	**Last Name***	
Genetic Sex* ○ Male ○ Female Gender Identification (optional): _____	**Date of Birth* (mm/dd/yyyy)**	
Ancestry ○ White/Caucasian ○ Hispanic ○ Black/African American ○ Native American ○ East Asian ○ South Asian ○ Middle Eastern ○ Ashkenazi Jewish ○ Other: _____		
Email		
Address		
City	State	Zip Code
Primary Phone		

SAMPLE INFORMATION

Date Sample Collected* (mm/dd/yyyy)	Medical Record #
Specimen Type* ○ Blood ○ Buccal Swab	

ORDERING PROVIDER INFORMATION

Ordering Provider GeneDx Account Number*	**Ordering Provider GeneDx Account Name***	
Ordering Provider Name*	**NPI Number***	
Role/Title	Specialty	
Address*		
City*	**State***	**Zip Code***
Phone*	**Send Report Via*** ○ Email ○ Fax: _____	
Ordering Provider Email*		
SEND ADDITIONAL REPORT COPY TO:		
Additional Provider Name	NPI Number	
Role/Title	Specialty	
Reporting Preference(s): ○ Email ○ Fax: _____		
Email		

PROGRAM BILLING

GeneDx Account Number ZU015	**Company Name/Sponsor** Taysha Gene Therapies

TEST CODE	TEST NAME	GENE LIST
737	Hereditary Neuropathy Panel	Genes included: *AARS, ABHD12, AIFM1, ATL1, ATL3, ATP7A, BAG3, BICD2, BSCL2, CHCHD10, CNTNAP1, COX6A1, CYP27A1, DNAJB2, DNM2, DNMT1, DST, DYNC1H1, EGR2, ELP1, RETREG1, FBXO38, FGD4, FIG4, GAN, GARS, GDAP1, GJB1, GLA, GNB4, HADHA, HARS, HINT1, HSPB1, HSPB8, IGHMBP2, INF2, KARS, KIF1A, KIF5A, LITAF, LMNA, LRSAM1, MFN2, MME, MORC2, MPV17, MPZ, MTMR2, NDRG1, NEFH, NEFL, NGF, NTRK1, PDK3, PLEKHG5, PMP22, PNKP, PRDM12, PRPS1, PRX, RAB7A, REEP1, SBF1, SBF2, SCN11A, SCN9A, SCO2, SEPT9, SETX, SH3TC2, SIGMAR1, SLC12A6, SLC25A46, SLC52A2, SLC52A3, SLC5A7, SPG11, SPTLC1, SPTLC2, TFG, TRIM2, TRPV4, TTR, VAPB, VCP, VRK1, WNK1, YARS*

SPONSORED TESTING PROGRAM ELIGIBILITY & ORDERING PROVIDER ATTESTATION

ELIGIBILITY CRITERIA CONFIRMATION

The Ordering Provider attests the Patient is eligible for the Program, which is available to Patients who meet <u>all four</u> of the criteria listed below:

1. **The Patient must reside in the United States**
2. **The Patient must be affected with neuropathy**
3. **The Patient must not have prior genetic neuropathy confirmed by DNA test**
4. **The Patient must be 18 years old or younger**

ATTESTATION

By signing this form, the Ordering Provider acknowledges that the individual/family member authorized to make decisions for the individual (collectively, the "Patient") has been supplied with information regarding genetic testing, substantially as set forth in the Informed Consent section found on Page 3, and has consented to undergo genetic testing in connection with the sponsored testing program (the "Program"). The Ordering Provider (i) warrants that he/she will not seek reimbursement for this no-cost test from any third party, including but not limited to federal healthcare programs and (ii) will inform the Patient that he/she shall not seek reimbursement for this no-cost test from any third party, including but not limited to federal healthcare programs.

The Ordering Provider also hereby acknowledges that organization and healthcare provider contact information provided in this Test Requisition Form (TRF) may be shared with third parties that may contact the Ordering Provider directly in connection with the Program, and that they have made the Patient aware that third parties may contact their Ordering Provider regarding de-identified information gathered through the Program.

In addition to the above, the Ordering Provider attests that he/she is the ordering healthcare provider, and that he/she is authorized under applicable state law to order this test.

Patient Research Opt-Out

○ By checking this box, I confirm that the Patient wishes to opt out of being contacted for research studies.

New York Retention Opt-In (ONLY For Patients Who Are Residents of New York State)

○ By checking this box, I confirm that the Patient is a New York State resident who would like to give permission for GeneDx to retain any remaining sample longer than 60 days after testing has been completed.

Signature of Ordering Provider*	**Date***

*INDICATES REQUIRED FIELDS. PLEASE NOTE THAT AN INCOMPLETE FORM MAY RESULT IN TESTING DELAYS.

HEREDITARY NEUROPATHY PANEL SPONSORED BY TAYSHA GENE THERAPIES TEST REQUISITION FORM

GeneDx Account #	Account Name	
ZU015	Taysha Gene Therapies	
Patient First Name	Patient Last Name	Patient Date of Birth

CLINICAL INFORMATION *Please select all that apply:*

Physical Characteristic:

Curly (frizzy) hair: ○Yes ○No ○Unknown

Clinical Symptoms:

Abnormal gait or frequent falls: ○Yes ○No ○Unknown

Ataxia (lack of coordinated movement): ○Yes ○No ○Unknown

Gastrointestinal Symptoms (e.g. recurrent nausea and vomiting, reflux, constipation, lactose intolerance): ○Yes ○No ○Unknown

Facial muscle weakness: ○Yes ○No ○Unknown

Clinical Symptoms (cont'd):

Nystagmus or oculomotor abnormalities: ○Yes ○No ○Unknown

Bulbar dysfunction (e.g. dysarthria, dysphagia): ○Yes ○No ○Unknown

Scoliosis: ○Yes ○No ○Unknown

Contractures: ○Yes ○No ○Unknown

Learning difficulties: ○Yes ○No ○Unknown

Sensory or Sensorimotor Neuropathy: ○Yes ○No ○Unknown

Age of first symptom onset: _____ ○Years ○Months ○Unknown

TO AVOID TESTING DELAYS, PLEASE REMEMBER TO:

1. Complete the Patient Information, Ordering Provider Information and Sample Information sections (* denotes a required field)
2. Sign the Program Eligibility & Ordering Provider Attestation section
3. Complete the Clinical Information section above
4. Label each sample with TWO identifiers (Patient Name and Date of Birth) that match those on this completed Test Requisition Form
5. List the Date of Collection on each sample and/or this completed Test Requisition Form
6. Include this completed Test Requisition Form with the collected sample(s) and ship together to GeneDx

FOR MORE INFORMATION, EMAIL TAYSHA@GENEDX.COM

DISCLAIMER

By choosing to participate in this Taysha Gene Therapies sponsored testing program ("the Program"), Ordering Provider understands GeneDx will send aggregate, de-identified test results data to Taysha Gene Therapies for research and/or commercial purposes, and that GeneDx is compensated for the provision of testing services and for data sharing with Taysha that is compliant with applicable law. At no time does Taysha Gene Therapies receive any personally identifiable information. Taysha Gene Therapies may receive contact information for Ordering Providers who use this Program. Neither Ordering Providers nor Patients who use this Program have any obligation to recommend, purchase, order, prescribe, promote, administer, use or support any Taysha Gene Therapies product now or in the future.

INFORMED CONSENT

GeneDx Account #	Account Name	
ZU015	Taysha Gene Therapies	
Patient First Name	Patient Last Name	Patient Date of Birth

For the purposes of this consent, "I", "my", and "your" will refer to me or to my child, including my unborn child, if my child is the person for whom the healthcare provider has ordered testing.

PURPOSE OF THIS TEST

The purpose of this test is (a) to see if I may have a genetic variant or chromosome rearrangement causing a genetic disorder; or (b) to evaluate the chance that I will develop or pass on a genetic disorder in the future. If I already know the specific gene variant(s) or chromosome rearrangement that causes the genetic disorder in my family, I agree to inform the laboratory of this information.

WHAT TYPE OF TEST RESULTS CAN I EXPECT FROM GENETIC TESTING?

1. Positive: A change in your DNA was found, which is very likely the cause of your features/symptoms. This is the most straightforward test result, which can be used as the basis to test other family members to determine their chances of having either the disease or a child with the disease.
2. Negative: No variants were found to explain your symptoms. This does not mean that you do not have a genetic condition. It is still possible that there is a genetic variant not found by the test that was ordered. Your healthcare provider or genetic counselor may discuss more testing either now or in the future.
3. Variant of Uncertain Significance (VUS): A change in a gene was found. However, we are not sure whether this variant is the cause of your symptoms/features. More information is needed. We may suggest testing other family members to help figure out the meaning of the test result.
4. Unexpected Results: In rare instances, this test may reveal an important genetic change that is not directly related to the reason for ordering this test. For example, this test may find you are at risk for another genetic condition you are not aware of or it may indicate differences in the number or rearrangement of sex chromosomes. We may disclose this information to the ordering healthcare provider if it likely affects medical care.

Because medical and scientific knowledge is constantly changing, new information that becomes available may supplement the information GeneDx used to interpret my results. Healthcare providers can contact GeneDx at any time to discuss the classification of an identified variant.

RISKS AND LIMITATIONS OF GENETIC TESTING

1. In some cases, testing may not identify a genetic variant even though one exists. This may be due to limitations in current medical knowledge or testing technology.
2. Accurate interpretation of test results may require knowing the true biological relationships in a family. I understand that if I fail to accurately state the biological relationships in my family, it could lead to incorrect interpretation of the test results, incorrect diagnoses, and/or inconclusive test results. If genetic testing reveals that the true biological relationships in a family are not as I reported them, including non-paternity (the reported father is not the biological father) and consanguinity (the parents are related by blood), I agree to have these findings reported to the healthcare provider who ordered the test.
3. Although genetic testing is highly accurate, inaccurate results may occur for a number of reasons. These reasons include, but are not limited to, mislabeled samples, inaccurate reporting of clinical/medical information, rare technical errors, or other reasons.
4. I understand that this test may not detect all of the long-term medical risks that I might experience. The result of this test does not guarantee my health and that additional diagnostic tests may still need to be done.
5. I agree to provide an additional sample if the initial sample is not adequate.

PATIENT CONFIDENTIALITY AND GENETIC COUNSELING

It is recommended that I receive genetic counseling before and after having this genetic test. I can find a genetic counselor in my area at *www.nsgc.org*. Further testing or additional consultations with a healthcare provider may be necessary.

To maintain confidentiality, test results will only be released to the referring healthcare provider, the ordering laboratory, to me, to other healthcare providers involved in my care, diagnosis and treatment, or to others with my consent or as permitted or required by law. Federal laws prohibit unauthorized disclosure of this information. More information can be found at: *www.genome.gov/10002077*

SAMPLE RETENTION

After testing is complete, my sample may be de-identified and be used for test development and improvement, internal validation, quality assurance, and training purposes. GeneDx will not return DNA samples to you or to referring healthcare providers, unless specific prior arrangements have been made.

I understand that samples from residents of New York State will not be included in the de-identified research studies described in this authorization and GeneDx will not retain them for more than 60 days after test completion, unless specifically authorized by my selection. The New York Retention Opt-In authorization is optional, and testing will be unaffected if my healthcare provider does not check the box for the New York authorization language. GeneDx will not perform any tests on the biological sample other than those specifically authorized.

DATABASE PARTICIPATION

De-identified health history and genetic information can help healthcare providers and scientists understand how genes affect human health. Sharing this de-identified information helps healthcare providers to provide better care for their patients and researchers to make new discoveries. GeneDx shares this type of information with healthcare providers, scientists, and healthcare databases. GeneDx will not share any personally identifying information and will replace the identifying information with a unique code not derived from any personally identifying information. Even with a unique code, there is a risk that I could be identified based on the genetic and health information that is shared. GeneDx believes that this is unlikely, though the risk is greater if I have already shared my genetic or health information with public resources, such as genealogy websites.

SPONSORED TESTING PROGRAM PARTICIPATION

In addition to the above, by choosing to participate in this sponsored testing program ("the Program"), I understand that GeneDx will send aggregate, de-identified test results data to the Sponsor for research and/or commercial purposes and that GeneDx is compensated for the provision of testing services and for data sharing with Taysha that is compliant with applicable law. At no time does the Sponsor receive any personally identifiable information. The Sponsor may receive contact information for healthcare providers who use this Program. Healthcare providers and Patients who use this Program have no obligation to recommend, purchase, order, prescribe, promote, administer, use or support any Taysha Gene Therapies product.

PATIENT RECONTACT FOR RESEARCH PARTICIPATION

In addition to the Program, GeneDx may collaborate with other scientists, researchers and drug developers to advance knowledge of genetic diseases and to develop new treatments. If there are opportunities to participate in research relevant to the disorder in {my/my child's} family, GeneDx may contact my healthcare provider for research purposes, such as the development of new testing, drug development, or other treatment modalities. In some situations, such as if my healthcare provider is not available, I may be contacted directly. I can opt out of being contacted directly regarding any of the above activities by having my healthcare provider check the box for the Patient Research Opt-Out. Any research that results in medical advances, including new products, tests or discoveries, may have potential commercial value and may be developed and owned by GeneDx or the collaborating researchers. If any individuals or corporations benefit financially from these studies, no compensation will be provided to {my/my child} or {my/my child's} heirs.