CONSENT FOR GENETIC TESTING AND PARTICIPATION IN SPONSORED TESTING PROGRAM

Novo Nordisk is providing the NovoDETECT™ Primary Hyperoxaluria (PH) Panel or NovoDETECT™ Nephrolithiasis (Kidney Stone) Panel (the "Genetic Test") under a sponsored genetic testing program (the "Program") to healthcare providers and their patients to help identify rare genetic diseases of recurrent kidney stones. If the Genetic Test finds 1 or more genetic variants of unknown significance (inconclusive results) in the genes associated with PH, then the Program will direct the patient to submit a urine specimen for further testing (the "Urine Test").

The Genetic Test will be performed by Blueprint Genetics ("Blueprint") in a CLIA-certified clinical DNA testing laboratory. The Urine Test will be performed by Quest Diagnostics ("Quest") in a CLIA-certified clinical testing laboratory. Blueprint is a Quest company. Under the Program, if necessary, based on the results of the Genetic Test, the Urine Test will be provided at no charge to patients. But patients will be responsible for the cost of their routine office visits and any other costs related to standard of care.

I/MY CHILD, _____, (Print Patient's First and Last Name)
agree to participate in the Program and request and permit Blueprint to analyze MY/MY CHILD'S genetic information in the buccal (cheek swab) or blood sample provided to Blueprint in connection with the Program as described in this Consent.

I/MY CHILD, _____, (Print Patient's First and Last Name)
further agree to participate in the Program and request and permit Quest to analyze MY/MY CHILD'S urine sample provided to Quest in connection with the Program as described in this Consent.

I confirm that the following information has been explained to me and that I have chosen to give my consent by signing and returning this completed Consent to Blueprint by following the instructions in the sample collection kit. I understand that I can withdraw my consent, at any time, by reaching out to support.us@blueprintgenetics.com. I understand that if I withdraw my consent before I receive my test result, I/MY CHILD will no longer be eligible for the Program and that I will not receive my test result and MY/MY CHILD'S sample will be destroyed.

I UNDERSTAND AND AGREE THAT:

1. The purpose of the Genetic Test, which will be conducted by Blueprint and is paid for by Novo Nordisk, is to identify gene variants that may increase a person's risk of rare genetic diseases of recurrent kidney stones. The Genetic Test provided under the Program shall be performed on the blood or buccal samples provided. I understand that the results of this Genetic Test may show that I and/or my family members have an inherited disease or are at an increased risk of being affected by a genetic disease. I understand that this Genetic Test may detect previously unrecognized biological relationships, such as non-paternity.

2. The Genetic Test provided under the Program requires that I/MY CHILD provide a blood or buccal (cheek swab) specimen for testing, which will be conducted by Blueprint. My healthcare provider has explained the risks associated with a blood draw (if applicable), and I consent to the specimen being collected, shared with, and analyzed by Blueprint. Blueprint has a laboratory in Finland as well as in the United States, and my specimen may be tested outside the United States, as necessary, to comply with applicable laws.

3. I am aware that the results of this Genetic Test might be inconclusive about MY/MY CHILD'S genetic status. While some genetic variants are known to be disease-causing and others are known to be benign (not disease-causing or do not cause disease), a portion of genetic variants found are of uncertain significance. In the event of a genetic VUS in the AGXT, GRHPR, or HOGA1 gene, I/MY CHILD will be asked to submit a urine sample for further testing. I/MY CHILD will be contacted to provide the urine sample through ExamOne services. ExamOne, like Blueprint, is a Quest company. I authorize Quest to provide Blueprint with a copy of the results of the Urine Test, if one is performed.

4. My healthcare provider may recommend genetic counseling or further testing of myself and/or my family members. Genetic counseling will be provided at no charge as part of this Program. If my healthcare provider recommends genetic counseling, I authorize the genetic-related counselor and related support team to contact me.

5. The results of the Genetic Test in the form of a clinical report will be released to the healthcare provider(s) listed on the test requisition form. If a Urine Test is performed, another clinical report on that test will also be released to the healthcare provider. It will be at the discretion of MY/MY CHILD'S healthcare provider to determine next steps, including, but not limited to, possible eligibility for future clinical trials or other research opportunities based on MY/MY CHILD'S Genetic Test results.

   I understand that a summary of results from this Genetic Test and, if applicable, Urine Test with no names or other personal-identifying information ("De-identified Results") may be presented, for example, at meetings, in scientific publications, and/or in DNA-variant databases to improve the understanding, diagnostics, and treatment of similar clinical conditions. No personal-identifying information will ever be presented with the results.

6. Blueprint may also disclose De-identified Results and other information to Novo Nordisk for the purposes of carrying out the Program. Novo Nordisk may store, use, and disclose De-identified Results for its business purposes, research, and publication, and to conduct other analyses. MY/MY CHILD'S name or other personal identifying information will not be used in or connected to the test results in any educational materials, presentations, or other publications. Novo Nordisk will take steps to protect my De-identified Results from use or disclosure in a manner not permitted under applicable laws and regulations.

7. I understand that my DNA and, if applicable, urine samples, test results, and related information will not be disclosed by Blueprint or Quest for purposes of any decision to grant or deny any insurance, employment, mortgage, loan, credit, educational, or similar opportunity.
Vermont Residents: Pursuant to Vermont law, I understand that I must be notified that my Genetic Test and, if applicable, Urine Test results may become part of my permanent medical record and may be material to my ability to obtain certain insurance benefits. However, as noted above, I also understand that my samples, test results, and related information will not be disclosed by Blueprint or Quest for purposes of any decision to grant or deny any insurance, employment, mortgage, loan, credit, educational, or similar opportunity.

I am aware that the separate consent listed below is OPTIONAL and that my decision is voluntary. I understand that not consenting to the separate consent listed below will not in any way affect my further treatment or my ability to receive this Genetic Test and, if applicable, the Urine Test. If no box is checked in a section, it is assumed that no consent is given.

OPTIONAL CONSENT TO ALLOW CONTACT FOR FUTURE RESEARCH
By checking the box below, I give my consent for Blueprint and Quest to contact me about further genetic research and/or other genetic services relevant to ME/MY CHILD in the future.
I may withdraw my permission to receive such communications at any time by contacting Blueprint at (650) 452-9340.

☐ I give my consent for Blueprint and Quest to contact me as described herein.

More information about how we process personal data: https://blueprintgenetics.com/privacy/

BY SIGNING BELOW, I AGREE TO THE FOLLOWING

I, the undersigned, have reviewed the information in this Consent, including information regarding the possible benefits and risks of the Genetic Test. I understand that, under the Program, participating in the Urine Test is required, if indicated. I have been given the opportunity to ask questions before I sign this document and have been told that I can ask additional questions at any time. I consent to the Genetic Test and, if applicable, the Urine Test and participation in the Program as described in this Consent.	
Patient name (please print):	**Patient date of birth (YYYY-MM-DD):**
Patient signature:	**Date (YYYY-MM-DD):**
Name and relationship of Legal Representative, if patient is a minor (please print):	**Signature of Legal Representative, if patient is a minor:**

Please submit this form, along with your sample, in the kit provided, and mail it using the prepaid shipping label.

For questions, please call NovoDETECT™ at (833) 472-2999 (Monday-Friday, 8 am-8 pm EST) to speak with a Blueprint Genetics support team member.