



Genetic Mutation Worksheet

Information regarding your patient's genetic testing

Fax completed form, along with the patient's START form, to 1-800-621-5203

Please use this worksheet as a guide to understand whether your patient is appropriate for therapy.

What is the date of last genetic test performed for this patient?

Month _____ Year _____ Do not know This patient has never had a genetic test

Please note: If your patient does not have a genetic test, please obtain one and then complete this form.

What is the name of the lab that performed the genetic test for this patient?

Name _____

Please note: Some managed care organizations might request a copy of the genetic test to get started on a therapy in a timely manner. Please provide a copy, if available.

Based on the results of the genetic test, what type of mutation (or genotype) does this patient have? (Please select only one)

Deletion Duplication Point mutation None of the above Do not know

Where is the location of this patient's deletion(s) on the gene?

Single deletion, located at exon _____

Example: exon 50

Deletion range, located at (enter first and last missing exons; enter as many ranges as necessary):

exon _____ to exon _____

Examples:

exon 45 to exon 50

exon 48 to exon 50 and exon 52

exon _____ to exon _____

exon _____ to exon _____

Which exon skip is your patient amenable to?

Exon 51 Exon 53 Exon 45 Exon 44 Exon 50 Exon 52 Exon 55

If you have any additional comments about this patient's exon deletion, you may enter this information below.

Physician Information

First Name:		Last Name:	
Center Name:		Address:	
City:	State:	ZIP:	Phone Number:
Signature: _____			



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05/16 C-SRP-51-US-0159

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Please contact us with any questions

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