myome | atlas™

Provider Overview

Assess Inherited Alzheimer's Disease Risk with the *APOE* Add-On

APOE genotyping from whole-genome sequencing (WGS) to assess inherited risk for late-onset Alzheimer's disease (AD), with genotype-associated cardiovascular and lipid considerations.



Test Overview

Reveal *APOE* Genotype

WGS is used to determine six *APOE* genotypes by characterizing the variants that define the three common alleles (ε2, ε3, ε4).

Assess Late-Onset AD Risk

Genotype information is used to report associated late-onset AD risk relative to the population baseline.

Inform Lipid Screening

Reports interpret genotype-specific lipid effects, such as the ε2/ε2 link to type III hyperlipoproteinemia.

Ordering Workflow

Patient* (aged 18+)

New Patient
Ordered alongside Curated Screen at no additional cost

Existing Curated Screen Patient
Ordered as a re-requisition — no new patient sample required

WGS and Analysis

New Patient
APOE genotyped from the Curated Screen dataset

Existing Curated Screen Patient
Existing dataset re-queried for *APOE* genotype

Report

New Patient
Standalone *APOE* report delivered in ~5–6 weeks, separately from the Curated Screen report

Existing Curated Screen Patient
Standalone *APOE* report delivered in ~1 week

Risk Categories Reported

Three common *APOE* alleles produce six genotypes. Each report assigns one of three risk categories.

Genotype	Population frequency	Lifetime AD risk†	Risk category
ε2/ε2	<1%	Lower than average[3]	**Decreased**
ε2/ε3	~10–15%	Slightly lower than average	
ε3/ε3	~60% (most common)	Population baseline (~10–15%)[1,2]	**Average**
ε2/ε4	~2%	Slightly higher than average	**Increased**
ε3/ε4	~20–25%	~20–25% by age 85[4]	
ε4/ε4	~2–3%	~50–60% by age 85[4]	

*Intended for asymptomatic adults; not diagnostic. Does not assess early-onset AD genes (*APP*, *PSEN1*, *PSEN2*). †Risk estimates are derived primarily from studies of individuals of European ancestry and vary by sex and age horizon; both risk magnitude and allele frequency differ across ancestral populations.

1. Goldman JS, et al. Genet Med. 2011;13(6):597-605. doi:10.1097/GIM.0b013e31821d69b8. 2. Liu CC, et al. Nat Rev Neurol. 2013;9(2):106-118. doi:10.1038/nrneurol.2012.263. 3. Reiman EM, et al. Nat Commun. 2020;11:667. doi:10.1038/s41467-019-14279-8. 4. Genin E, et al. Mol Psychiatry. 2011;16(9):903-907. doi:10.1038/mp.2011.52.

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Patient Consent Considerations



APOE testing is not for every patient. Because it is an active selection (never included by default), the ordering conversation is where the decision to test should be made. Clinical guidelines recommend pre- and post-test genetic counseling when *APOE* testing is performed.[1] Pre-test counseling is the responsibility of the ordering provider. Before ordering the *APOE* Add-On, consider discussing:

- *APOE* results are probabilistic. Many ε4 carriers do not develop AD, and non-carriers do.
- The result cannot predict whether or when symptoms would begin.
- Results can cause distress, particularly for ε4 carriers, and cannot be unlearned. Patients have the opportunity to decline.
- MyOme offers access to post-test genetic counseling*.
- GINA† does not protect against discrimination in life, disability, or long-term care insurance.

*via a third-party provider — DNAvisit. †GINA: Genetic Information Nondiscrimination Act.

How *APOE* Risk Can Inform Proactive Care

An *APOE* result is most valuable when it changes a conversation. Three ways it can:

Lipid screening and risk management	• ε4 is associated with modestly higher LDL cholesterol, and ε2/ε2 carries a rare but treatable risk of type III hyperlipoproteinemia — results can inform lipid screening regardless of AD risk. • Genotype awareness may also motivate action on modifiable risk factors: cardiovascular health, physical activity, hearing, sleep, and cognitive and social engagement.
Treatment considerations and evolving options	• ε4 carriers — particularly ε4/ε4 — face a higher risk of ARIA (amyloid-related imaging abnormalities) with FDA-approved anti-amyloid therapies, making genotype relevant if therapy is ever considered • Knowing their status helps patients stay informed as therapies and guidelines evolve.
Family implications and planning	• First-degree relatives (parents, siblings, children) have a ≥50% chance of sharing an identified allele. • A result can prompt personal, family, and care planning conversations and inform decisions about whether other biological relatives may want testing.

Important Test Considerations

- *APOE* Add-On must be actively selected at ordering; it is never included by default. If the Curated Screen order is cancelled, the *APOE* add-on is cancelled with it.
- Standard Atlas monogenic consent applies; no additional consent form is required.
- Risk estimates are derived primarily from European-ancestry cohorts and may over- or understate risk in other populations.

Get Started Today

Login to the Provider Portal → Order Test or Re-Requisition → Collect Sample (if new patient) → Receive Results‡ → Genetic Counseling

Learn More

‡Receive results in 5–6 weeks for new orders and ~1 week for re-requisitions.

1. Goldman JS, et al. Genetic counseling and testing for Alzheimer disease: joint practice guidelines of the American College of Medical Genetics and the National Society of Genetic Counselors. Genet Med. 2011;13(6):597-605. doi:10.1097/GIM.0b013e31821d69b8.

This test was developed, and its performance characteristics determined, by MyOme, Inc., a clinical laboratory certified under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) and College of American Pathologists (CAP) accredited to perform high-complexity clinical laboratory testing. This test has not been cleared or approved by the U.S. Food and Drug Administration (FDA). Test results should always be interpreted by a clinician in the context of clinical and familial data and with the availability of genetic counseling when appropriate.

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