#### **Supplemental Materials**

#### **Supplemental Acknowledgement**

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#### Conflicts of interest:

LA receives research support for research from Eli Lilly, Takeda, Illumina, Boehringer Ingelhiem, Biogen, Orchard Therapeutics. LA serves on the scientific advisory boards of the MLD Foundation, CureMLD, and Don't Forget Morgan Foundation. She is also a consultant for Takeda, Biogen, and Orchard Therapeutics. RD receives grant support from Takeda, Biogen, Orchard Therapeutics, Affinia, and Sana. EMB received research support from AB2Bio and is a consultant for Sobi and Genzyme. RGM and AADJ receive research support through the NIH intramural research program (IRP) at NIAID. AV receives grant and in-kind support for research from Eli Lilly, Gilead, Takeda, Illumina, Boehringer Ingelhiem, Biogen, Homology, Ionis, Passage Bio, Affinia, Sana, Sanofi, Myrtelle, and Orchard Therapeutics. She also serves on the scientific advisory boards of the European Leukodystrophy Association and the United Leukodystrophy Foundation as well as in an unpaid capacity for Takeda, Ionis, Biogen, and Illumina.

# **Supplemental Table 1. Examples of health conditions present in Control Cohorts**



# **Supplemental Table 2. Comparison of cohorts by sample**



# **Supplemental Table 3. Comparison of cohorts by subject**



**Supplemental Table 4: Comparison of different approaches to AGS 6 genes by AUC** (with 95% CI) and pvalue (for comparison with median AGS 6 genes) in Training Data Set (N = 258) and Test Data Set (N = 739). (See Consort Diagram in Figure 1b.)



**Supplemental Table 5: Sensitivity, Specificity, and Number of samples needed to misdiagnose (NNM)** for a test based on the optimal cut-point (obtained using Youden Index) in the Test Data Set that contains the AGS Cohort (N = 165) and Control Cohort 1 (N = 77). (See Consort Diagram in Figure 1b.)



\*The values in this column are equal in Supplemental Tables 5 and 6.

\*\*Number Samples Needed to Misdiagnose (NNM), assuming prevalence (*prev*) of AGS = 10% (5%, 15%); harm of false negative (*C*) is twice that of false positive results; and sensitivity (*se*), specificity (*sp*) are as estimated for a test that classifies a sample as AGS if the classifier is >= each of the cut-points in Table 3A. The weighted number to misdiagnose (1) (NNM) =  $\frac{1}{g_{\text{current}}}$  $\frac{1}{\text{C\times} \text{prev}(1-\text{se}) + (1-\text{prev}) \times (1-\text{sp})}$ .

**Supplemental Table 6: Sensitivity, Specificity, and Number of samples needed to misdiagnose (NNM)**  for a test based on the optimal cut-point (obtained using Youden Index) in the Test Data Set that contains the AGS Cohort (N = 165) and Control Cohorts 1 and 2 combined (N = 574). (See Consort Diagram in Figure 1b.)



\*The values in this column are equal in Supplemental Tables 5 and 6.

\*\*Number Samples Needed to Misdiagnose (NNM), assuming prevalence (*prev*) of AGS = 10%, (5%, 15%); harm of false negative (*C*) is twice that of false positive results; and sensitivity (*se*), specificity (*sp*) are as estimated for a test that classifies a sample as AGS if the classifier is >= each of the cut-points in Table 4A. The weighted number to misdiagnose (NNM) =  $\frac{1}{c \times prev(1-se)+(1-prev) \times (1-sp)}$ .

**Supplemental Table 7: False Positive, False Negative, Positive Predictive Value (PPV), Negative Predictive Value (PPV)** for a test based on the optimal cut-point (obtained using Youden Index) in the Test Data Set that contains the AGS Cohort ( $N = 165$ ) and Control Cohort 1 ( $N = 77$ ). (See Consort Diagram in Figure 1b.)



\*The values in this column are equal in Supplemental Tables 7 and 8.

\*\*Positive Predictive Value, assuming prevalence (*prev*) of AGS = 10% (5%,15%); sensitivity (*se*), and specificity (*sp*) are as estimated for a test that classifies a sample as AGS if the classifier is >= each of the cut-points in Table 3B. The positive predictive value  $=\frac{ sens \times prev}{sens \times prev + (1-spec) \times (1-prev)}$ .

\*\*Negative Predictive Value, assuming prevalence (*prev*) of AGS = 10% (5%,15%); sensitivity (*se*), and specificity (*sp*) are as estimated for a test that classifies a sample as AGS if the classifier is  $>=$  each of the cutpoints in Table 3B. The negative predictive value  $=\frac{spec\times(1-prev)}{spec\times(1-prev)+(1-sens)\times prev}.$ 

**Supplemental Table 8: False Positive, False Negative, Positive Predictive Value (PPV), Negative Predictive Value (PPV)** for a test based on the optimal cut-point (obtained using Youden Index) in the Test Data Set that contains the AGS Cohort (N = 165) and Control Cohorts 1 and 2 combined (N = 574). (See Consort Diagram in Figure 1b.)



\*The values in this column are equal in Supplemental Tables 7 and 8.

\*\*Positive Predictive Value, assuming prevalence (*prev*) of AGS = 10% (5%,15%); sensitivity (*se*), and specificity (*sp*) are as estimated for a test that classifies a sample as AGS if the classifier is >= each of the cut-points in Table 4B. The positive predictive value  $=\frac{ sens \times prev}{ sens \times prev + (1-spec) \times (1-prev)}$ .

\*\*Negative Predictive Value, assuming prevalence (*prev*) of AGS = 10% (5%,15%); sensitivity (*se*), and specificity (sp) are as estimated for a test that classifies a sample as AGS if the classifier is  $>=$  each of the cutpoints in Table 4B. The negative predictive value  $=\frac{spec\times(1-prev)}{spec\times(1-prev)+(1-sens)\times prev}.$ 

**Supplemental Table 9**. **Comparison of score performance in external validation dataset** containing the external individuals affected by AGS, CANDLE and SAVI.



#### **Supplemental Table 10.** Nucleotide sequences for probe A

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# **Supplemental Table 11.** Nucleotide sequences for probe B





# **Supplemental Table 12.** Synthetic DNA oligonucleotides used as a standard





# **Supplemental Table 13. Overview of Criteria used to Obtain Optimal Values on ROC Curves- Prevalence**



a false positive (FP). We let  $C =$  the harm due to FN divided by the harm due to FP. We assume  $C = 2$  and obtain the cut-point at which the Weighted Number Needed to Misdiagnose is maximized, where the Weighted Number to Misdiagnose =  $1/[C \times FN + FP] = 1/[T (1 - 2C) + (1 - 2C)]$  x (1 – prevalence) + C  $x(1 -$  sensitivity) x prevalence].

- 1. Habibzadeh F, Habibzadeh P, and Yadollahie M. On determining the most appropriate test cut-off value: the case of tests with continuous results. *Biochem Med (Zagreb).* 2016;26(3):297-307.
- 2. Crow YJ, Chase DS, Lowenstein Schmidt J, Szynkiewicz M, Forte GM, Gornall HL, et al. Characterization of human disease phenotypes associated with mutations in TREX1, RNASEH2A, RNASEH2B, RNASEH2C, SAMHD1, ADAR, and IFIH1. *Am J Med Genet A.* 2015;167a(2):296-312.
- 3. Rice GI, Forte GM, Szynkiewicz M, Chase DS, Aeby A, Abdel-Hamid MS, et al. Assessment of interferon-related biomarkers in Aicardi-Goutieres syndrome associated with mutations in TREX1, RNASEH2A, RNASEH2B, RNASEH2C, SAMHD1, and ADAR: a case-control study. *The Lancet Neurology.* 2013;12(12):1159-69.
- 4. Rice GI, Melki I, Fremond ML, Briggs TA, Rodero MP, Kitabayashi N, et al. Assessment of Type I Interferon Signaling in Pediatric Inflammatory Disease. *J Clin Immunol.* 2017;37(2):123-32.