

Prior Authorization Form

NOTE: Refer to the Provider Manual for additional services requiring **Prior Authorization**



Fax Form To: Grand Rapids – 616 942-0024 Holland – 616 392-7626 ASO – 616 395-4090 Traverse City – 231 932-9505 Farmington Hills – 888 647-6152

Breast and Ovarian Cancer Screening by Molecular Testing

(Please refer to Genetic Counseling, Testing and Screening Medical Policy #91540 for additional information.)

Member

Date: _____

Last Name: _____ First Name: _____

ID #: _____ DOB: _____

Plan/Product Type: EPO HMO POS SF-POS PPO Medicare

Member Risk Category: (check those risk categories that apply)

- Three or more affected first or second degree relatives on same side of family, irrespective of age at diagnosis, or There are fewer than three relatives, but
- There are multiple primary or bilateral breast cancers in the patient or one family member, or
- A family member has been identified with a detectable mutation, or
- There are one or more cases of ovarian cancer at any age, AND one or more members on the same side of the family with breast cancer at any age, or
- There is breast cancer in a male patient, or in a male relative, or
- The patient is at increased risk for specific mutation(s) due to ethnic background (for instance: Ashkenazi Jewish descent) AND has one or more relatives with breast cancer or ovarian cancer at any age, or
- The patient was diagnosed with breast cancer at 45 years of age or less or ovarian cancer at any age.

Notes:

1. At least one of the above risk categories must apply for consideration of genetic testing. If none of the above applies please provide a detailed letter of explanation of medical necessity.
2. Completion of risk category does not necessarily mean testing is appropriate or will be automatically approved. Completion of Prior Authorization Form does not guarantee payment. Payment of covered services is subject to the provider's contract, the member's eligibility on the dates of service rendered, and specific provisions of the member's health benefits plan. If prior authorization is not obtained, member may be liable for the cost of the testing.
3. Members who seek coverage for BRCA1/2 testing for the benefit of OTHER family members must seek reimbursement of payment from the OTHER family member's insurance carrier. BRCA analysis for the medical management of OTHER family members is not a covered benefit for Priority Health members.
4. A 3-generation pedigree must be appended to this request. Documentation of specific cancer diagnosis in the proband(s) and pertinent medical records as well as a letter of medical necessity may be required prior to authorization.
5. **Genetic Counseling must be done prior to testing by a board certified *Genetic Counselor or Geneticist that is independent of the laboratory performing the testing.**
* Genetic counselors are defined by the plan as American Board of Medical Genetics or American Board of Genetic Counseling certified physicians or masters or doctorate level-trained genetic counseling professionals who have received formal training in genetics and genetic counseling from an accredited institution.

Patient Education:

Consistent with the 1997 National Institute of Health Consensus Statement on guidelines for care of patients with BRCA1 and BRCA2 mutations and American College of Medical Genetics guidelines, genetic counseling should occur both prior to and after testing. Also, prior to testing and follow-up treatment, the patient must give informed consent in accordance with applicable law. Consistent with such guidelines, informed consent discussions should include at least the following:

1. Clarification of the patient's increased risk status
2. Explanation of how genetics affects cancer susceptibility
3. Potential benefits, risks, limitations of (and alternatives to) testing
4. Possible outcomes of testing (e.g., positive, negative, or uncertain test results)
5. Limited data regarding efficacy of methods for early detection and prevention
6. Possible psychological and social impact of testing
7. Counseling regarding therapeutic options, including limitations

By signing this form, I certify that the member listed above has been given informed consent in accordance with the guidelines and risks above and that the BRCA analysis will be used to direct the medical management of this patient.

Physician Name: _____ Physician Signature: _____

*Certified Genetic Counselor / Geneticist Name: _____

Phone: _____ Contact Name: _____

*****ALL FIELDS MUST BE COMPLETE AND LEGIBLE FOR PRIOR AUTHORIZATION REVIEW*****