# General Genetic Testing Authorization Form

**(including breast and ovarian cancer screening)**
**Fax Form To: 888.647.6152**

PriorityHealth
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Clear Form

☐ **Check if your facility is participating as an in network provider for Cigna.**
**Please refer to *Genetics: Counseling, Testing and Screening Medical Policy #91540* for additional information.**

## Member:

Date: _____

Last name: _____ First name: _____

Address: _____

ID #: _____ DOB: _____

## Provider:

Name of provider ordering testing: _____ Tax ID: _____

Contact name: _____ Phone: _____ Fax: _____

## Patient Counseling* (must be completed prior to request):

Name of certified *genetic counselor or medical geneticist: _____

Clinic/Facility: _____ Date of counseling: _____

Contact name: _____ Phone: _____ Fax: _____

***See *Genetics: Counseling, Testing, Screening Medical Policy #91540* for specific test criteria and genetic counseling requirements.**

## Test Requested:

Name of specific test(s): _____

CPT code(s): _____

ICD-9 code(s): _____

## Directed To:

Facility/Laboratory: _____ Tax ID#: _____

Address: _____

Contact name: _____ Phone: _____ Fax: _____

## Member's personal clinical history related to testing being requested:

Required supportive documentation **must** include summary notes from a board certified genetic counselor or medical geneticist (not affiliated with the testing lab) and pedigree.

_____

_____

_____

## Family history related to testing being ordered if applicable (please indicate if relationship to member is maternal or paternal, i.e. maternal aunt, paternal cousin):

Relationship: _____ Diagnosis: _____ Age at time of diagnosis _____

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## Other relevant information related to testing being ordered:

_____

_____

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# Prior Authorization Form

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

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**Fax Form To: 888.647.6152**

## General Genetic Testing (including Breast and Ovarian Cancer Screening)

**Please refer to *Genetics: Counseling, Testing and Screening Medical Policy #91540* for additional information.**

### Member:

Last name:_____ First name: _____

ID #:_____

### Notes:

1. 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.
2. Members who seek coverage for genetic testing for the benefit of OTHER family members that do not also have Priority Health insurance must seek reimbursement of payment from the OTHER family member's insurance carrier.
3. 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.
4. **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

*Health care practitioners in the State of Michigan must follow state law regarding informed consent for predictive genetic testing. (Michigan State Law. 333.17020 Genetic test; informed consent.
http://www.legislature.mi.gov/(S(jib1q43uw35mcelqnqmaalyc))/mileg.aspx?page=GetObject&objectname=mcl-333-17020h

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 results will be used to direct the medical management of this patient.

Physician name:_____Physician signature:_____

*Certified genetic counselor / geneticist name: _____

Phone:_____ Contact name: _____

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