Important note:
Even though this policy may indicate that a particular service or supply may be considered covered, this conclusion is not based upon the terms of your particular benefit plan. Each benefit plan contains its own specific provisions for coverage and exclusions. Not all benefits that are determined to be medically necessary will be covered benefits under the terms of your benefit plan. You need to consult the Evidence of Coverage to determine if there are any exclusions or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and your plan of benefits, the provisions of your benefits plan will govern. However, applicable state mandates will take precedence with respect to fully insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, Federal mandates will apply to all plans. With respect to Senior Care members, this policy will apply unless Medicare policies extend coverage beyond this Medical Policy & Criteria Statement. Senior Care policies will only apply to benefits paid for under Medicare rules, and not to any other health benefit plan benefits. CMS's Coverage Issues Manual can be found on the CMS website.

SERVICE: Genetic (Genomic) Testing

PRIOR AUTHORIZATION: Required.

POLICY:

Overarching Principles: All genetic testing should be used for predictive, diagnostic or prognostic disease situations. Genetic testing for non-medical purposes, such as paternity, ancestry, genome-wide association studies (GWAS), and non-disease traits, such as baldness, eye color, are NOT medically necessary. Most genetic testing is once per lifetime or once per pregnancy (prenatal testing). When possible, testing should be performed at a contracted/network laboratory. If a non-contracted (out-of-network) laboratory is required, the member should be informed of difference in out-of-pocket charges. In addition, the provider should document the need for an out-of-network laboratory, e.g., targeted testing in another family member, gene not offered at contracted/network laboratory, etc. Finally, medical necessity must be documented in every request.

For genetic/genomic requests, InterQual® will be used to determine medical necessity when possible. If criteria are not available through InterQual®, this policy will be used to determine medical necessity.

Coverage for genetic/genomic testing and/or screening may be medically necessary when all of the following criteria are met:

1. Appropriate genetic counseling occurs before and after testing.
   Members must have genetic counseling by a practitioner who has expertise in the genetic aspects of the condition being evaluated and who will discuss the results of the test and their clinical implications. Documentation of the counseling will accompany the preauthorization request.
   Evidence of genetic counseling should include, but is not limited to the following:
   - discussion of the types of test results (positive, negative, uncertain findings) that could be obtained,
   - identifying problems that are known to occur due to test methodology,
   - evaluation of the members risk for the specific disorder, the differential diagnosis, inheritance patterns, penetrance, variable expressivity and genetic heterogeneity
   - evidence of informed consent
   - a plan for posttest counseling

   Note: genetic counseling must be performed by practitioners NOT employed by testing companies due to conflict of interest.

2. There must be a reasonable expectation, based on family history, pedigree analysis, risk factors, and/or symptomatology, that a genetically inherited or acquired condition exists and the member displays clinical features, or is at direct risk of inheriting the mutation in question (pre-symptomatic) or
comes from the appropriate disease-specific population. A three-generation pedigree MUST accompany the request for testing, to aid in coverage determination, unless indicated otherwise in the discussion below.

3. Knowledge of the presence or absence of the condition would DIRECTLY affect medical care of the member:
   a. The disease must be treatable and/or preventable AND
   b. The test results will lead to a change in the intensity of surveillance frequency and /or treatment for that disease.

4. There are often options for single gene testing, multiple gene testing and panel testing.
   a. If a single gene test meets other criteria and will answer the clinical question, SHWP will generally find such a test medically necessary.
   b. If a multigene panel is requested, there must be evidence that there are two or more genes responsible for a specific condition or that there is the possibility that several genes can cause multiple diseases within the family. Most of the genes on the panel should be plausible explanations for the disorder observed
   c. The smallest plausible gene panel will be authorized, to decrease variants of unknown significance. Broad multi-gene-based panels are not medically necessary when a more focused study is available.
   d. If a panel is chosen, the list of genes should be on the request and in the accompanying documentation to explain why that particular panel was chosen
   e. Multiple panels tested at the same time are not medically necessary

5. The test is performed in a CLIA certified laboratory, AND is FDA approved, AND is recommended by recognized, national guidelines.

6. The request MUST be submitted with the SWHP “Statement of Medical Necessity for Genetic Testing” OR other documentation such as clinical documentation that addresses all of the questions in that document. In particular there must be a clear statement that explains how the test results will improve the medical management of the patient’s condition. The statement “… is medically necessary” does NOT meet the criteria since it does not explain the change in management or surveillance that would take place if the test is positive and if it were negative.

Note: Genetic/genomic testing for specific germline conditions or mutations is limited to once per lifetime for the specific mutation or panel. Exceptions may be considered if there is a change in guidelines for genes that have not been tested or need reinterpretation of results.

Eight medically appropriate genetic testing categories appear in Sections A through H. These sections identify providers authorized to order the tests and give examples of indications for testing.

A. Prenatal Testing (does not require a three-generation pedigree). Testing will be covered for the number of genes necessary for a diagnosis. A tiered approach may be necessary.
   1. Prenatal screening using maternal serum analysis (in first and/or second trimester) and nuchal translucency measurement may be medically necessary for all pregnant women following criteria set forth by the American Congress of Obstetricians and Gynecologists (ACOG). These are not “genetic” tests; therefore, the prior authorization requirement for this policy does not apply.
   2. Non-invasive prenatal testing (NIPT) (CPT 81420) for aneuploidy using tests that analyze circulating cell-free DNA extracted from a maternal blood sample may be medically necessary when appropriate genetic counseling (to include: false positive and false negative results, an explanation that this is a screening, not diagnostic test, and that there is a variety of screening options) has been provided by a practitioner who has expertise in the genetic aspects of the conditions being evaluated PRIOR TO testing, AND one of the following criteria are met:
a) Maternal age of 35 or older at time of delivery
b) Fetal ultrasound findings, or positive first or second trimester biomarker screening, indicate an increased risk of aneuploidy
c) There was a prior pregnancy with trisomy 13, 18, 21 or sex chromosome aneuploidy
d) Parental balanced translocation that can lead to a trisomy of 13, 18, 21 or sex chromosome aneuploidy

Cell-free DNA screening tests for microdeletions (CPT 81422) have NOT been validated and are not deemed medically necessary.

3. Prenatal diagnostic genetic testing (via amniocentesis or chorionic villus sampling) will be covered for pregnant women when the member has received genetic counseling from a practitioner who has expertise in the genetic aspects of this test, the reason for testing is documented, and the testing is ordered by a Maternal Fetal Medicine obstetrician or geneticist. Common indications for prenatal diagnosis include but are not limited to:
   a. Abnormal fetal ultrasound findings
   b. Abnormal maternal serum first trimester screening, second trimester triple or quad screen, integrated* or alpha-fetoprotein, elevated MSAFP, abnormal NIPT or advanced maternal age.
   c. Increased risk based on documented family history or carrier status

Note: Prenatal diagnostic genetic testing is NOT considered medically necessary for:
   a. Sex determination unless medically indicated
   b. Prenatal determination of paternity

Most plans do not include assisted reproduction (e.g. artificial insemination, IVF) as a benefit. In plans where assisted reproduction is a benefit, pre-conceptual testing of embryos may be medically necessary where there is a risk of vertical transmission of a genetic disease.

*Nuchal translucency (NT) measurement will only be covered when combined with first trimester serum screening (“combined testing”) at centers which have appropriate certification to do so by either the Fetal Medicine Foundation (FMF) or the Nuchal Translucency Quality Review Program (NTQR). Nuchal translucency measurement alone is not a covered benefit.

B. Genetic Carrier Screening: Indications for genetic carrier testing for at-risk individuals include but are not limited to:

1. Carrier screening for cystic fibrosis*(CF) and spinal muscular atrophy will be covered for ALL members who are either pregnant or considering pregnancy.
2. Carrier testing for other conditions, such as Fragile X and hereditary hemochromatosis, may be medically necessary for member(s) in any of the following groups:
   a. Members with a positive family history
   b. Members with a known mutation in the family
   c. Members whose self-reported ethnicity predicts an increased risk for specific autosomal recessive genetic disease(s)
   d. Reproductive member partners of member with a known autosomal recessive condition or a carrier of a known autosomal recessive condition
   e. When biochemical testing is not reliable.

Specifically for CF:
   ✓ Infant members who have a positive State Newborn Screen test for Cystic Fibrosis (CF)
   ✓ Members with signs and symptoms of CF, or who have a sweat chloride test that is intermediate, inconclusive or cannot be performed.

*Covered testing is for a core panel of 25 mutations that are recommended by the American College of Medical Genetics (ACMG) medically necessary for cystic fibrosis genetic testing. The standard mutation panel is available at: http://www.ama-assn.org/ama/no-index/about-ama/3021.shtm. Testing for additional CF mutations through an expanded panel will be covered for certain indications when recommended by a genetic counselor.
Note: When criteria are met, only one test during the member’s life would be considered medically necessary.

C. Suspected Genetic Conditions/ Diagnostic testing:
Careful consideration must be given to genetic testing and screening of members to ensure that use of this technology promotes the best interest of the member. Identification of the genetic condition must clearly benefit the medical management of the member. Testing must be requested by a practitioner who has expertise in the genetic aspects of the condition being evaluated and who will discuss the results of the test and their clinical implications with the member/family. Documentation of counseling MUST accompany request.

SWHP may consider testing medically necessary to confirm a suspected genetic condition in the following situations when there are national guidelines that support testing, e.g., Fragile X in a member with mental retardation and/or autism, member with symptoms of SMA, etc.:

1. Chromosomal analysis by routine chromosome analysis or chromosomal microarray in a member with:
   a. multisystem malformations or suspected of having a specific genetic disorder
   b. a suspected chromosomal abnormality
   c. unexplained failure to thrive in infancy, developmental delay, loss of developmental milestones, unusual growth patterns,
   d. multiple stillbirths or multiple miscarriages
2. There may be instances where a member was tested in a research laboratory, and to be able to change management confirmatory testing of the abnormality in another lab is necessary. This specialized condition may be considered medically necessary when:
   a. Confirmatory single site testing is performed in a CLIA approved laboratory, AND
   b. The confirmatory result will change management or surveillance.

Note: Tests to confirm or rule-out suspected genetic conditions in symptomatic individuals are covered only when confirming a diagnosis would ALTER the medical management for the individual. The request must include an explanation of what and how the medical management will be changed based on the testing outcome.

D. Diagnostic testing for Oncology testing:
Diagnostic testing in oncology is used when a member already has cancer and meets certain family history, or other guidelines that indicate that they are at risk for an inherited cancer family syndrome. ALL of the following criteria must be met.

1. Tests must be accurate and performed in laboratories that have documented sensitivity and specificity to support testing.
2. There is documentation of the medical necessity, i.e., the change of management based on the results.
3. Genetic counseling to include, pedigree, stage and biomarkers of the tumor, age of onset, meaning of positive, negative and variants of unknown significance (VUS) results, and the medical necessity of testing
4. Appropriate gene or gene panel be ordered with possibility of reflex testing to expanded panel
5. Once per lifetime however, exceptions may be considered with advancing technology
6. The minimum gene or panel should be tested. If there is a previous abnormality that has been tested, that gene only should be tested. Every effort should be made to obtain a copy of the report and that testing be performed in the same lab as the reported abnormality.

E. Prognostic and predictive Oncology testing (does not require a three generation pedigree):
A prognostic biomarker is a biomarker that provides information on the likely course of the cancer in an untreated individual. Some examples include, but are not limited to the following:

1. Chromosomal analysis or chromosomal microarray for hematologic malignancies
2. Prognostic testing for breast cancer (e.g. Prosigna, Mammoprint, Oncotype Dx)
3. Prognostic testing assay in prostate cancer (e.g. Prolaris, Decipher, Oncotype DX prostate)
4. HLA genotyping for Celiac associated DQ alleles when serologic testing and or intestinal biopsy results are inconsistent with one another or clinical presentation.

A predictive biomarker is defined as a marker which can be used to identify subpopulations of patients who are most likely to respond to a given therapy. Some examples include, but are not limited to the following:

1. Her2 neu testing in breast cancer
2. Kras testing in colon cancer
3. Braf testing in melanoma

Note: SWHP will cover prognostic and predictive genetic testing ONLY when ordered by a practitioner who has expertise in the genetic aspects of the condition being evaluated and who will discuss the results of the test and their clinical implications. It is expected that practitioner will guide the member in carefully weighing all options during presentation of the testing results.

F. Predictive Genetic Testing: Predictive testing is offered to asymptomatic individuals with a family history of a genetic disorder. Predictive testing is of two types:

- Pre-symptomatic (eventual development of symptoms is certain when the gene mutation is present, e.g., Huntington disease)
- Pre-dispositional (eventual development of symptoms is likely but not certain when the gene mutation is present, e.g., breast cancer).

SWHP will cover hereditary pre-disposition/pre-symptomatic genetic testing when the following conditions are met:

1. The member is asymptomatic but has a family history of the disorder in a first or second degree relative. **IF POSSIBLE**, there should be documentation regarding testing in the affected relative BEFORE undertaking testing of an unaffected member to clarify a negative result. If an unaffected relative cannot be tested, such documentation should accompany the request. Third degree relatives may be considered depending on the size of the family. Documentation of counseling of the unaffected member including problems with such testing by a practitioner who has expertise in the genetic aspects of the condition being evaluated, must accompany the request. A pedigree **MUST** accompany the request.

   **NOTE**: If ordering a panel of genes, each gene on the panel MUST be indicated for testing by the pedigree.

2. For a family member with a history of ovarian cancer, there MUST be documentation, or an attempt to obtain documentation, supporting the diagnosis of ovarian cancer versus some other type of “female” cancer. Genetic testing, when relatives having “ovarian cancer” lack confirmatory documentation of ovarian cancer, may not be considered medically necessary. The documentation might include:
   a. Age of diagnosis, type of treatment, treatment failures and how the disease progressed, age of death, OR
   b. Death certificate, OR
   c. Information from tumor registry at the hospital where the individual was diagnosed; OR
   d. Documentation of failed attempt to obtain confirmation of history.

3. The test is being requested by a practitioner who has expertise in the genetic aspects of the condition being evaluated and who will discuss the results of the test and their clinical implications.

4. The following documentation is provided:
   a. Documentation of the impact of this testing on the medical management of the member; AND
   b. Genetic counseling has been accomplished; AND
   c. A three generation pedigree or documentation of 3 generations including maternal and paternal
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sides of the family

d. Informed consent has been obtained; AND
e. The results of familial mutation/tests are available upon request.

Because only the minimum gene or panel should be tested, if there is a previous abnormality that has been identified, that gene only should be tested. Every effort should be made to obtain a copy of the report. If possible, testing should be performed in the same lab as the reported abnormality.

Predictive/predisposition testing may be medically necessary ONLY if early diagnosis allows interventions which reduce morbidity or mortality or change the medical monitoring/management of the patient. Specifics about the change in management or documentation should accompany the request.

G. Results from tumor profiling leading to germline testing.
Sometimes members undergo tumor profiling for diagnostic purposes. On occasion those results indicate the possibility of a germline mutation. In those cases, it is recommended by NCCN guidelines, that germline testing for the specific gene be obtained. All of the following must be met:
1. Genetic counseling is required by genetic professionals due to the type of results that are obtained before undergoing germline testing with family history documentation
2. VUS results do not qualify for testing
3. Sequencing of the gene should be performed rather than a targeted mutation test

H. Pharmacogenetics.
Adverse drug reactions are cause of morbidity and mortality. Some of these adverse reactions are caused by genetic-based individual difference in drug absorption, disposition and metabolism. The Clinical Pharmacogenetics Implementation Consortium (CPIC) provides well-documented guidelines regarding the use of genetic/genomic testing in clinical practice. These are available at: https://www.pharmgkb.org/view/dosing-guidelines.do?source=CPIC.

In order for a pharmacogenetics/genomic test to possibly be medically necessary, it must be recommended by CPIC or some other nationally recognized guideline (including FDA) and the problems of the member with the specific drug (i.e. non response or adverse reaction to the specific drug or class of drugs) must be listed in the medical necessity form.

Testing may be considered medically necessary when ALL of the following criteria are met. Testing is once/lifetime.
1. Testing is performed in a CLIA certified laboratory
2. Testing is NOT being performed as part of a panel of genes and only significant genes per guidelines will be tested
3. The particular genes have not been previously tested
4. The medications label requires testing results to safely use the medication or a patient has had a significant side effect where testing is recommended by national guidelines
5. The provider will use the test results to impact medical care.

Note: for pharmacogenetics requests, a three generation pedigree is not necessary.

The following are considered to be experimental and investigational:
Whole Genome Sequencing, exome sequencing, genome-wide association studies, mitochondrial whole genome analysis

Whole genome sequencing (WGS), also known as full genome sequencing (FGS), complete genome sequencing, or entire genome sequencing is a laboratory procedure which seeks to determine an individual's entire DNA sequence, specifying the order of every base pair within the genome at a single
time. The relationship between mutations in the genomic material of asymptomatic individuals and the development of specific diseases is still being analyzed and the role of whole-genome sequencing in the clinical setting has yet to be established.

Exome sequencing, also referred to as whole exome sequencing or WES, is an alternative to WGS. It is a laboratorv process to determine the sequence of the protein coding regions of the genome. The exome is the part of the genome that encodes protein, where roughly 85 percent of variants are known to contribute to diseases in humans. Exome sequencing has been proposed as a diagnostic method to identify these genetic variants in patients not diagnosed by traditional diagnostic and genetic testing approaches.

Genome-wide association studies (GWAS), also referred to as genome-wide analysis, is a method of identifying genes involved in human disease by comparing the genome of individuals with a disease or condition to the genome of individuals without the disease or condition. GWAS are performed using microarrays to search the genome for small variations, called single nucleotide polymorphisms (SNPs), that occur more often in individuals with a specific disorder than in those who do not have a disorder.

Mitochondrial Whole Genome Analysis (MITO-WGA)

Mitochondrial disease represents a heterogeneous group of conditions with the same etiology: a mutation which impairs the function of the mitochondrial electron transport chain. Dysfunction of the mitochondria can cause any of a variety of conditions and symptoms: progressive external ophthalmoplegia, optic atrophy, retinitis pigmentosa, proximal myopathy, exercise intolerance, sensorineural deafness, encephalopathy, seizures, and ataxia.

Because there is currently no consensus on genotype/phenotype relationship or how to incorporate this information into direct medical management, the use of WGS, WES, GWAS or MITO-WGA is considered to be experimental and investigational.

The following tests considered experimental and investigational and are NOT considered medically necessary:

a. Genetic testing (e.g., presenilin-1 gene, apolipoprotein E epsilon 4 allele, amyloid precursor gene, etc.) for the diagnosis and assessment of persons with Alzheimer disease and related dementias.

b. Genetic testing for complex eye disorders such as age-related macular degeneration and late-onset primary open angle glaucoma, PreDx Diabetes Risk Test™, deCODE T2™, deCODE AF™, deCODE MI™, deCODE Glaucoma, deCODEme Cancer, deCODE BreastCancer™ and BREVAGen™ Breast Cancer Risk Stratification Test deCODE ProstateCancer 9p21Mi Check, and deCODEme Cardio.

c. Most hereditary multigene, next generation (next-gen) sequencing panels, or other cancer panels (e.g., BRCAplus, BreastNext™, CancerNext™, ColoNext™, Foundation Heme™, OvaNext™) to determine susceptibility to hereditary cancers, to diagnose cancer or determine treatment.

Exclusions:
The following are examples of services that are not covered:
1. Routine, ongoing, or long term genetic counseling.
2. Genetic testing to determine the paternity of a child.
3. Genetic testing to determine the sex of the child.
4. General population screening for genetic disorders (e.g., cystic fibrosis).
5. ApoE for hyperlipidemia and/or Alzheimer’s Disease.

Definitions:
First-degree relative – a blood relative with whom an individual shares approximately 50% of his or her genes, including parents, full siblings and children

Second-degree relative – a blood relative with whom an individual shares approximately 25% of his/her genes, including grandparents, grandchildren, aunts, uncles, nephews, nieces and half-siblings.
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MANDATES: None

CODES:

Important note:
CODES: Due to the wide range of applicable diagnosis codes and potential changes to codes, an inclusive list may not be presented, but the following codes may apply. Inclusion of a code in this section does not guarantee that it will be reimbursed, and patient must meet the criteria set forth in the policy language.

<table>
<thead>
<tr>
<th>CPT Codes:</th>
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<tbody>
<tr>
<td>HCPCS Codes:</td>
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<tr>
<td>ICD-10:</td>
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<td>ICD-10 Not covered:</td>
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CMS: There is no NCD.

POLICY HISTORY:

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<th>Date</th>
<th>Action</th>
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<td>12/06/2011</td>
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<td>07/02/2015</td>
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<td>09/08/2016</td>
<td>Clarified criteria; added pharmacogenetics section.</td>
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<td>06/27/2017</td>
<td>Updated criteria for NIPT.</td>
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<td>08/22/2017</td>
<td>Set most testing limit to once per lifetime. Updated criteria. New request form.</td>
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<td>Minor correction</td>
<td>11/28/2017</td>
<td>Removed discussion regarding FIT-DNA stool testing</td>
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<tr>
<td>Reviewed</td>
<td>06/26/2018</td>
<td>Significant revision of several coverage topics.</td>
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<tr>
<td>Addition</td>
<td>02/12/2019</td>
<td>InterQual to be used instead of policy for five codes.</td>
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REFERENCES: The following scientific references were utilized in the formulation of this medical policy. SWHP will continue to review clinical evidence surrounding genetic testing and may modify this policy at a later date based upon the evolution of the published clinical evidence. Should additional scientific studies become available and they are not included in the list, please forward the reference(s) to SWHP so the information can be reviewed by the Medical Coverage Policy Committee (MCPC) and the Quality Improvement Committee (QIC) to determine if a modification of the policy is in order.

6. Croitoru ME, Cleary SP, Di Nicola N, Manno M, Selander T, Aronson M, Redston M, Cotterchio M,
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13. ACOG Committee Opinion 690, March 2017: Carrier screening in the age of genomic medicine


15. American College of Obstetricians and Gynecologists Committee Opinion No 691: Carrier screening for genetic conditions carrier screening for genetic conditions 2017


17. American College of Medical Genetics and Genomics Practice Guidelines
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SWHP Genetic Testing Prior Authorization Form

6/26/2018 version

Date of Request: ___/____/_______ Date, if procedure has been scheduled: ___/____/_______

Insured Member Information:

Name: ____________________________ SWHP ID #: ___________________ Date of birth: ___/____/_______

Gender: M F

Provider Information:

Requesting Provider Name: __________________________ Requesting Provider NPI: _________________________

Requesting Provider Address: _______________________________________________________________________

Office Contact Person: __________________________ Telephone #: __________________ Fax #: ________________

Supplying Provider Information:

Supplying Provider Name: ____________________________

Supplying Provider Address: _______________________________________________________________________

Office Contact Person: __________________________ Telephone #: __________________ Fax #: ________________

Genetic Test Information:

Requested Genetic Test:

☐ BRCA 1 and 2, HBOC ☐ Breast expression RNA ☐ Hereditary Hemochromatosis Gene Analysis

☐ Colon Cancer Lynch Syndrome (list genes) ☐ Cystic Fibrosis ☐ Fragile X Syndrome

☐ Huntington’s Disease ☐ Janus Kinase 2(JAK2) ☐ Chromosomial Microarray

☐ Familial Adenomatous Polyposis /Assoc. Polyposis Conditions ☐ Cardiology Gene Expression (AlloMap) ☐ NIPS (non-invasive prenatal screen)

☐ Multigene panel: Please list genes requested

ICD-10 Codes:

CPT Code Test

CPT Code Test
Medical Information:

Provide information to justify each test requested. (May attach dictation if it contains requested information.)

1) Why is the test appropriate for the patient? _______________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

2) Does the beneficiary exhibit clinical features of the mutation in question? If not, has a genetic variant been identified in a family member? (May attach dictation if it contains requested information.)
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

3) Has the patient given informed consent to the genetic test? □ Yes □ No

4) Has genetic counseling occurred? □ Yes □ No   By whom? ________________________________________________

5) What is the validity of testing and is the testing scientifically sound? (reference or link)
__________________________________________________________________________________________________
__________________________________________________________________________________________________

6) Is the patient willing to undergo the increased interventions that may potentially be required because of testing?
□ Yes  □ No

7) How will the results specifically impact or alter medical management of the patient?
__________________________________________________________________________________________________
__________________________________________________________________________________________________

8) What is the cost of the test? _____________________________________________________________

9) Is multigene panel testing more cost efficient than the combined reimbursement for single codes? ______________

Signature of Requesting Provider: ____________________________Date: ___/___/_____