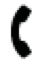
Prior Authorization Genetic Testing Form

FYI Incomplete, illegible or inaccurate forms will be returned back to sender. Failure to provide required documentation may result in denial of request.

Fax form and any relevant clinical documentation to: Clinical Intake at **612-884-2094.**



For questions, **call** Provider's Services Center at: **612-676-3300** or **1-888-531-1493**

PATIENT INFORMATION	UCare ID ____________________ Date of Birth ___________ Phone _________________ Member Name ____ Address ____ City, State, Zip ____
ORDERING PROVIDER INFORMATION	Ordering Provider Name ________________________ ID/NPI Number _________________ Address ____ City, State, Zip ____ Phone _________________________________ Fax _______________________________
SERVICE PROVIDER INFORMATION	Service Provider Name _________________________ ID/NPI Number _________________ Address ____ City, State, Zip ____ Contact Person ____ Phone _________________________________ Fax _______________________________
SERVICE PROCEDURE REQUESTED	Dates of Service ________________ Test Name ____ CPT/Codes ____ ICD – 10 ____ Total Pages Faxed _________

Prior Authorization – Genetic Testing Form (continued)

CRITERIA FOR GENETIC TESTING

Criteria for Genetic Testing: (Please include clinical notes)

- A personal or family medical history suggests a genetic mutation that increases the risk of a given medical condition.
- There is documentation (please include) that knowledge of the test results will directly impact the medical management of the patient because:
  - ✓ The disease is treatable and/or preventable
  - ✓ The results will change the frequency, intensity or type of surveillance or treatment of the condition
  - ✓ The change in medical management is highly likely to result in a reduced risk of morbidity and/or mortality
- Testing recommendations are in accordance with existing guidelines (e.g. NCCN, ACMG, ACOG, Medicare, Medicaid).
- The testing is FDA/CLIA approved.
- The testing has been shown to be clinically valid by peer-reviewed literature (e.g. Hayes® criteria).
- The patient has not had prior genetic testing for the same disease/condition (In general, genetic testing should only be performed once in a lifetime).
- The person ordering the test is also the provider who will be using the results to manage the patient.
- Documentation included of genetic counseling that includes a pedigree, appropriate risk assessment, informed consent, discussion of the test's limitations and the psycho-social implications of the results from one of the following providers who is not affiliated with the genetic testing lab:
  - ✓ Board-eligible or board certified genetics counselor
  - ✓ Medical geneticist
  - ✓ Other provider with expertise in genetics (e.g. oncologist, surgeon, gastroenterologist)

Additional Information that may support medical necessity:

____

____

____

☐ **I certify that the above criteria are met. I also attest that this patient/member has given informed consent for the requested testing and that the results of this testing will be used by me to directly impact the management plan.**

Signature of Ordering Clinician ______________________________ **Date** ______________________