

**Review Request for
Genetic Testing for Cancer Susceptibility**

Please fax the completed form to **1-800-823-5520**.

If you have questions, call **1-866-902-1689** during regular business hours.

Provider Data Collection Tool Based on Medical Policy GENE.00001



Policy Last Review Date: 11/19/2009		Policy Effective Date: 01/13/2010		Provider Tool Effective Date: 07/14/2010	
Member Name:			Date of Birth:		
Insurance Identification Number:			Member Phone Number:		
Ordering Provider Name and Specialty:			Provider ID Number:		
Office Address:					
Office Phone Number:			Office Fax Number:		
Rendering Provider Name and Specialty:			Provider ID Number:		
Office Address:					
Office Phone Number:			Office Fax Number:		
Facility Name:			Facility ID Number:		
Facility Address:					
Date/Date Range of Service:			Place of Service: <input type="checkbox"/> Home <input type="checkbox"/> Inpatient		
Service Requested (CPT required):			<input type="checkbox"/> Outpatient <input type="checkbox"/> Other: _____		
Diagnosis (ICD-9 required):					

Please check all that apply to the member:

Genetic Counseling (Must be completed for every request)

- The individual undergoing genetic testing will receive genetic counseling (if checked, complete below)
- The testing is being offered in a setting with adequately trained health care professionals to provide appropriate pre- and post-test counseling
- Other (please describe): _____

BRCA1 and BRCA2

- Request is for genetic testing for a BRCA1 or BRCA2 mutation
- Request is for genetic testing for large rearrangements in BRCA1 and BRCA2 genes (the BRACAnalysis® Rearrangement Test [BART])

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Please check all of the following criteria that apply:

- Individual with breast cancer who has one relative with breast cancer diagnosed at an early age (especially <45 years)
- Individual with breast cancer diagnosed at an early age (premenopausal)
- Individual with breast cancer associated with multiple primary cancers or bilateral disease
- Individual with ovarian cancer, primary peritoneal cancer, or fallopian tube cancer
- Men who developed breast cancer at any age
- Individual has one or more first-degree relatives who meet any of the following criteria (check all that apply):
 - Breast cancer who has one relative with breast cancer diagnosed at an early age (especially <45 years)
 - Breast cancer diagnosed at an early age (premenopausal)
 - Breast cancer associated with multiple primary cancers or bilateral disease
 - Male relative who developed breast cancer at any age
 - Ovarian cancer
 - Primary peritoneal cancer
 - Fallopian tube cancer
- Individual has breast cancer with two or more first, second or third degree relatives (related through a single lineage) with breast or ovarian cancer
- Individual has relatives with documented mutations in either the BRCA1 or BRCA2 gene
- Individual has family history of three or more relatives with breast or ovarian cancer, at least one of which is a first or second degree relative
- Individuals with (a) breast cancer, or who have at least one first-, second- or third-degree relative with breast or ovarian cancer at any age, **and** (b) who belong to a population at risk for specific mutations due to ethnic background (e.g., Ashkenazi Jewish, Icelandic, Swedish or Hungarian descent).
- Other (please describe): _____

Hereditary Non-Polyposis Colorectal Cancer (HNPCC)

- Request is for genetic testing to detect mutations in the HNPCC genes for an individual with (check all that apply):
 - Two HNPCC-related cancers, (colorectal cancer, endometrial cancer, bile duct cancer, pancreatic cancer, ureteral cancer, ovarian cancer, brain tumor), including synchronous and metachronous colorectal cancers or associated extracolonic cancers
 - Colorectal cancer and a first-degree relative with colorectal cancer or HNPCC-related extracolonic cancer or colorectal adenoma; one of the cancers diagnosed at age less than 50 years, and the adenoma diagnosed at age less than 40 years.
 - Colorectal cancer or endometrial cancer diagnosed at age less than 50 years
 - Right-sided colorectal cancer with an undifferentiated pattern on histopathology diagnosed at age less than 45 years
 - Signet ring cell type colorectal cancer (diagnosed at age less than 45 years)
 - Adenomas diagnosed at age less than 40 years
 - A first- or second-degree relative with a known HNPCC mutation
- Other (please describe): _____

Familial Adenomatous Polyposis (FAP)

- Request is for genetic testing to detect mutations in the Familial Adenomatous Polyposis (FAP) genes for a individual with: (check all that apply)
- Greater than 20 adenomatous colonic polyps during his/her lifetime
 - First-or second degree relatives diagnosed with Familial Adenomatous Polyposis (FAP)
 - First-or second degree relatives with a known FAP gene mutation
- Other (please describe): _____

MYH-associated Polyposis (MAP)

- Request is for genetic testing for MYH-associated polyposis (MAP) for an individual with: (check all that apply):
- Greater than 10 adenomatous colonic polyps or greater than 15 cumulative adenomas in 10 years
 - A recessive inheritance (family history positive only for siblings)
 - Previous testing for adenomatous polyposis coli (APC) with negative results
 - Asymptomatic siblings with known MYH-associated polyposis (MAP).
- Other (please describe): _____

Medullary Thyroid Cancer and Multiple Endocrine Neoplasia Type 2 (MEN2), RET testing

- Request is for genetic testing for the RET proto-oncogene point mutations for the purposes of assessing multiple endocrine neoplasia type 2 (MEN2) or medullary thyroid cancer risk
- Individual meets the following criteria (check all that apply):
- Individual is from a family with defined RET gene mutations
 - Individual is from a family known to be affected by inherited medullary thyroid cancer but not previously evaluated for RET mutations
 - Individual has sporadic medullary thyroid cancer
- Other (please describe): _____

This request is being submitted:

- Pre-Claim
- Post-Claim. If checked, please attach the claim or indicate the claim number: _____

I attest the information provided is true and accurate to the best of my knowledge. I understand that BlueChoice HealthPlan Medicaid may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

Name and Title of Provider or Provider Representative
Completing Form and Attestation (Please Print)*

Date

* The attestation fields must be completed by a provider or provider representative in order for the tool to be accepted.