

Review Request for Genotype Testing

for Genetic Polymorphisms to Determine Drug Metabolizer Status

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.000010



Medicaid

Policy Last Review Date: 05/21/2009	Policy Effective Date: 07/15/2009	Provider Tool Effective Date: 03/17/2009
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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 if known):	<input type="checkbox"/> Outpatient <input type="checkbox"/> Other: _____
Diagnosis (ICD-9) if known:	

Please check all that apply to the member:

- Request is for genotype testing for genetic polymorphisms of (check all that apply):
 - Human Leukocyte Antigen B*1502 (HLAB*1502)
 - Cytochrome P450 (including CYP2C9)
 - Dihydropyrimidine dehydrogenase (DPYD)
 - Leukocyte Antigen B*1502 (HLAB*1502) [except where noted above]
 - Thymidylate synthetase (TYMS)
 - Uridine diphosphate glucuronosyltransferase 1A1 (UGT1A1)
 - Vitamin K epoxide reductase subunit C1 (VKORC1)
- Test is done to determine the drug-metabolizer status and: (check all that apply)
 - Use of Carbamazepine is proposed in the member

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Medicaid managed care administered by WellPoint Partnership Plan, LLC, an independent company.

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- Member is initiating therapy with: (check all that apply)
- 5-fluorouracil (5-FU)
 - Antidepressants or antipsychotics
 - Clopidogrel
 - Irinotecan
 - Phenytoin
 - Tamoxifen
 - Warfarin

Check all that apply to the member:

- The member is of Asian descent
- There are no other alternatives to the use of Carbamazepine

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.**