UnitedHealthcare®

Prior Authorization Facsimile Request Form: Genetic Testing for BRCA Mutations for UnitedHealthcare Commercial Health Plans

Date: _____

Ordering Physician/TIN#: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Member Name and Member ID#: _____

Thank you in advance for your cooperation. By supplying the requested information in a timely manner, you will help simplify this process for your patient. If you have any questions or need more information, please contact the Provider Services number on the back of the member's ID card.

Please complete Part B of this form for all members requesting prior authorization of genetic testing for BRCA mutations. Genetic counseling (Part A) is required if the member's Plan requires covered health services to be medically necessary. Please include the following clinical documentation with your request, if applicable:

1. Clinical notes documenting the genetic counseling encounter, including:
   - ☐ Personal history of cancer when applicable (please include cancer type and age of diagnosis)
   - ☐ Three-generation pedigree, including all cancers with age of diagnosis in maternal and paternal blood relatives. For prostate cancer, the Gleason score should be included.
   - ☐ Ethnicity/ancestry (include if the patient is Ashkenazi Jewish or from ethnic groups associated with founder mutations)
2. Complete Part A: Genetic Counseling Attestation form (to be completed by an independent genetics care provider)

Please fax the information to:

Utilization Management Review: 866-912-8464
Neighborhood Health Plan: 800-731-2515
UnitedHealthcare of the River Valley: 800-340-2184
UnitedHealthcare Oxford Plans: 800-303-9902
UnitedHealthcare: 866-756-9733

Part A: Genetic Counseling Attestation Form

Independent Genetic Care Provider Information:

Name: _____

Tax ID: _____

NPI: _____

Street Address: _____

City, State, Zip: _____

Telephone: _____

Fax: _____

Please choose one of the following recommendations:

☐ This individual meets UnitedHealthcare's Medical Policy criteria, and I support the testing requested. (please check the box under medical policy criteria that the individual meets and indicate relevant personal and/or family history details)

☐ This individual does not meet UnitedHealthcare's Medical Policy criteria for the testing requested.

☐ This individual does not meet UnitedHealthcare's Medical Policy criteria, but I support the testing requested for the reason(s) listed below:

Genetic Counseling Attestation:

☐ By checking this box, I affirm that I am one of the following types of providers (please check the care provider type box below), I am not employed by a commercial genetic testing lab, and I have personally performed genetic counseling with the indicated patient, including collection and assessment of attached documentation.

- ☐ A board-eligible or board-certified genetic counselor
- ☐ Advanced genetics nurse
- ☐ Genetic clinical nurse
- ☐ Advanced practice nurse in genetics
- ☐ A board-eligible or board-certified clinical geneticist
- ☐ A physician with experience in cancer genetics (defined as providing cancer risk on a regular basis and having received specialized ongoing training in cancer genetics. Educational seminars offered by commercial laboratories about how to perform genetic testing are not considered adequate training for cancer risk assessment and genetic counseling).

Signature: _____

Date: _____

Independent genetics care provider:
Genetic counseling by an independent (i.e., not employed by a genetic testing lab) genetics care provider is required before genetic testing for BRCA mutations so the member being tested is informed about the benefits and limitations of a specific genetic test. Genetics care providers employed by or contracted with a laboratory that is part of an integrated health system that routinely delivers health care services beyond laboratory testing itself are considered independent. Genetic testing for BRCA mutations requires documentation of medical necessity by one of the following genetics care providers who has evaluated the member and intends to engage in post-test follow-up counseling:

- Board-eligible or board-certified genetic counselor
- Advanced genetics nurse
- Genetic clinical nurse
- Advanced practice nurse in genetics
- A board-eligible or board-certified clinical geneticist
- A physician with experience in cancer genetics (defined as providing cancer risk on a regular basis and having received specialized ongoing training in cancer genetics. Educational seminars offered by commercial laboratories about how to perform genetic testing are not considered adequate training for cancer risk assessment and genetic counseling).

Part B:

Laboratory name: Invitae Corporation

Address: 1400 16th Street

City, State, Zip: San Francisco, CA 94103

TIN: 27-1701898

Phone number: (800) 436-3037

Laboratory test name: BRCA 1/2 Hereditary Breast and Ovarian Cancer Panel

Date of service (date of sample collection): _____

Diagnosis code: _____

CPT requested for authorization (please check all being requested):

☐ **81211** ☐ **81212** ☐ **81213** ☐ **81214** ☐ **81215** ☐ **81216** ☐ **81217** ☐ **81162** ☐ **81432** ☐ **81433**

Medical Policy Criteria

Please check which of the following criteria the member meets for genetic testing for BRCA mutations and provide the information requested:

☐ I. *BRCA1* and *BRCA2* testing is proven and medically necessary for women with a personal history of breast cancer in the following situations and where gene testing results will impact medical management:

☐ A. Breast cancer diagnosed at age 45 or younger with or without family history; or

☐ B. Breast cancer diagnosed at age 50 or younger with (check all that apply):

☐ An additional primary breast cancer; or

☐ At least one close blood relative with breast cancer at any age; or

- Please indicate family members including which side of family (i.e. maternal or paternal):

_____

☐ At least one close blood relative with pancreatic cancer; or

- Please indicate family members including which side of family (i.e. maternal or paternal):

_____

☐ At least one close blood relative with prostate cancer (Gleason score ≥7); or

- Please indicate family members including which side of family (i.e. maternal or paternal) and Gleason score: _____

_____

☐ An unknown or limited family history (see Definitions section for further clarification of limited family history)

- Limited family history explanation:

_____

_____

_____

☐ C. Breast cancer diagnosed at any age with (check all that apply):

☐ At least one close blood relative with breast cancer diagnosed at age 50 or younger; or

- Please indicate family members including which side of family (i.e. maternal or paternal):

_____

☐ At least two close blood relatives on the same side of the family with breast cancer at any age; or

- Please indicate family members including which side of family (i.e. maternal or paternal):

_____

☐ At least one close blood relative with ovarian cancer at any age; or

- Please indicate family members including which side of family (i.e. maternal or paternal):

_____

☐ At least two close blood relatives on the same side of the family with pancreatic and/or prostate cancer (Gleason score ≥7) at any age; or

- Please indicate family members including which side of family (i.e. maternal or paternal) and Gleason score: _____

_____

☐ Close male blood relative with breast cancer; or

- Please indicate family members including which side of family (i.e. maternal or paternal):

_____

☐ At least one close blood relative who has a *BRCA1* or *BRCA2* mutation (Testing should be targeted to the known *BRCA1*/*BRCA2* mutation in the family. Further *BRCA1*/*BRCA2* testing should only be pursued if the results are negative and the patient otherwise meets testing criteria); or

- Please indicate family members including which side of family (i.e. maternal or paternal): _____

☐ Ashkenazi Jewish or ethnic groups associated with founder mutations. Testing for Ashkenazi Jewish founder-specific mutations should be performed first. Further *BRCA1*/*BRCA2* testing should only be pursued if the results are negative and the patient otherwise meets testing criteria without considering Ashkenazi Jewish ancestry.

- Ethnicity/Ancestry: _____

☐ D. Triple-negative breast cancer diagnosed at age 60 or younger.

☐ II. *BRCA1* and *BRCA2* testing is proven and medically necessary for women with a personal history of ovarian cancer.

☐ III. *BRCA1* and *BRCA2* testing is proven and medically necessary for women and men with a personal history of pancreatic cancer at any age and at least one close blood relative on the same side of the family with breast (≤ age 50 years), ovarian, pancreatic and/or prostate cancer (Gleason score ≥7) at any age.

- Please indicate family members including which side of family (i.e. maternal or paternal), cancer including age and/or Gleason score: _____
  _____

☐ IV. *BRCA1* and *BRCA2* testing for Ashkenazi Jewish founder-specific mutations is proven and medically necessary for women and men with a personal history of pancreatic cancer and Ashkenazi Jewish ancestry.

- Ethnicity/ancestry: _____

☐ V. *BRCA1* and *BRCA2* testing is proven and medically necessary for men with a personal history of prostate cancer (Gleason score ≥7) at any age and at least one close blood relative on the same side of the family with breast (≤ age 50 years), ovarian, pancreatic and/or prostate cancer (Gleason score ≥7) at any age.

- Please indicate family members including which side of family (i.e. maternal or paternal), cancer including age and/or Gleason score: _____
  _____

☐ VI. *BRCA1* and *BRCA2* testing is proven and medically necessary for men with a personal history of breast cancer.

☐ VII. *BRCA1* and *BRCA2* screening tests are proven and medically necessary for men and women without a personal history of breast or ovarian cancer with at least one of the following familial risk factors only when there are no family members affected with a *BRCA* associated cancer available for testing (please check all that apply):

At least one first- or second-degree blood relative meeting any of the above criteria (I-V); or

- Please indicate family members including which side of family (i.e. maternal or paternal): _____

☐ At least one third-degree blood relative with breast cancer and/or ovarian cancer who has at least 2 close blood relatives with breast cancer (at least one with breast cancer at age 50 or younger) and/or ovarian cancer; or

- Please indicate family members including which side of family (i.e. maternal or paternal):

_____

☐ A known *BRCA1*/*BRCA2* mutation in a blood relative (defined as first-, second- or third-degree relative). Testing should be targeted to the known *BRCA1*/*BRCA2* mutation in the family. Further *BRCA1*/*BRCA2* testing should only be pursued if the results are negative and the patient otherwise meets testing criteria.

- Please indicate family members including which side of family (i.e. maternal or paternal):

_____