Blue Shield of California Statement of Medical Necessity Form	**Genetic Testing for Hereditary Breast and/or Ovarian Cancer Syndrome (BRCA1/BRCA2)**
View our Medical Policy on line at http://www.blueshieldca.com. **Medical Policy: 2.04.02**	
Patient Information	Provider Information
Name:	Provider Name:
Gender: ☐ Male ☐ Female	Tax ID Number:
Blue Shield ID Number:	Specialty: ☐ PCP ☐ Specialist (Please Identify):
Birth Date (mm/dd/yy):	Rendering Provider (Laboratory): **Invitae Corporation**
Date of Request (mm/dd/yy):	Rendering Provider ID Number: **NPI: 1316206220**

Coding Information

BRCA1 and BRCA2 Gene Analysis CPT Codes (check all that apply):
☐ **81162** (BRCA1 & 2; Full sequence & full duplication/deletion variants)
☑ **81211** (BRCA1 & 2; Full sequence & common duplication/deletion variants)

ICD-10 Codes (list all applicable codes):

Medical Necessity Criteria

BRCA1 and BRCA2 Mutation Testing: Genetic testing for BRCA1 and BRCA2 mutations in adults (at least 18 years of age or older) may be considered medically necessary when your patient meets the criteria set forth by Blue Shield of CA.
Please fill in all that apply so we can verify your patient meets the criteria for coverage.

	Patient	**First or Second Degree Blood relative** *(Parents, Siblings, Children, Grandparents, Aunts, Uncles, nieces, nephews, half-siblings, Grandchildren)*		**Third Degree Blood Relative** *(first-cousin, great-grandparents, great-grandchildren)*	
	Age of Diagnosis	Relative	Age of Diagnosis	Relative	Age of Diagnosis
History of breast cancer (including invasive and ductal carcinoma in situ)					
Two breast primaries at first cancer diagnosis (includes bilateral [collateral] disease or cases where there are two or more clearly separate [ipsilateral] primary tumors either synchronously or asynchronously)					
History of triple negative breast cancer (neither express estrogen receptor and progesterone receptor, nor overexpressed HER2)					
History of epithelial, ovarian, fallopian tube or primary peritoneal cancer					
History of Male breast cancer					
History of pancreatic cancer or aggressive prostate cancer (Gleason score >7) at any age					

I confirm that this test is medically necessary in accordance with Blue Shield of California medical policy and that the information provided is accurate and factual based on the patient's medical records and history. I confirm that this test is medically necessary for the risk and assessment, diagnosis or detection of a disease, illness, impairment, symptom, syndrome or disorder. The results will determine my patient's medical management and treatment decisions. I confirm that I have provided genetic testing information/counseling to the patient and they have consented to genetic testing.

Ordering Provider's Signature:_____ Date (mm/dd/yy): _____

* Review Medical policy for definition of "close blood relatives"; page 3 of 19. All information contained herein is subject to audit at any time by Blue Shield of California.