INVITAE

PROVIDENCE Express Care | at Home

| **Providence Health Plan**<br>Statement of Medical Necessity Form | **Genetic Testing for Hereditary Breast and/or Ovarian Cancer Syndrome (BRCA1/BRCA2)** |
|---|---|
| Patient Information | Physician Information |
| Name: | Physician Name: |
| Gender: ☐ Male ☐ Female | Tax ID Number: |
| Providence Health Plan ID Number:<br>☐ HMO ☐ PPO/ASO | Specialty: ☐ PCP ☐ Specialist ☐ Genetic Counselor<br>(Please Identify): |
| Birth Date (mm/dd/yy): | Rendering Provider (Laboratory): Invitae Corporation |
| Date of Service (mm/dd/yy): | Rendering Provider ID Number: NPI: 1316206220 |
| Has the patient undergone prior BRCA testing? ☐ Yes ☐ No | |

## 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 **any** of the following criteria are met (please check all applicable boxes):

☐ **Individual (male or female) from a family with a known deleterious BRCA1/BRCA2 mutation; List mutation (Identify gene):**
_____

☐ **Personal history of breast cancer (including invasive and ductal carcinoma *in situ*) and one or more of the following circumstances:**
- ☐ Diagnosed at age 45 or younger
- ☐ Two breast primaries when first breast cancer diagnosis occurred on or before 50 years of age (includes bilateral [contralateral] disease or cases where there are two or more clearly separate [ipsilateral] primary tumors either synchronously or asynchronously)
- ☐ Diagnosed on or before 50 years of age with one or more close blood relative with breast cancer at any age or with a limited family history
- ☐ Diagnosed on or before 60 years of age with triple negative breast cancer (neither express estrogen receptor and progesterone receptor, nor overexpressed HER2)
- ☐ Diagnosed at any age with one or more close blood relatives with breast cancer diagnosed on or before 50 years of age
- ☐ Diagnosed at any age with two or more close blood relatives with breast cancer at any age
- ☐ Diagnosed at any age with one or more close blood relatives with epithelial ovarian cancer
- ☐ Diagnosed at any age with two or more close blood relatives with pancreatic cancer or aggressive prostate cancer (Gleason score ≥7) at any age
- ☐ Close male blood relative with breast cancer
- ☐ Adult individual of ethnicity associated with higher mutation frequency (e.g., Ashkenazi Jewish, Norwegian, Dutch, or Icelander descent);
  *Please indicate maternal or paternal family member/s*:_____

☐ **Personal history of epithelial ovarian, fallopian tube or primary peritoneal cancer**

☐ **Personal history of male breast cancer at any age**

☐ **Personal history of pancreatic cancer or aggressive prostate cancer (Gleason score > 7) at any age with two or more close blood relatives with breast and/or ovarian cancer (including fallopian tube or primary peritoneal cancer), and/or pancreatic or aggressive prostate cancer (Gleason score > 7) at any age**

☐ **An adult without a personal history, but with a family history only of a:**
- ☐ First- or second-degree blood relative meeting any of the above criteria (Please indicate maternal or paternal family member & age)
  *Family Member*: _____ *Age*: _____(years) *Tumor type:* _____
- ☐ A third-degree blood relative with **both** of the following:
  · Breast cancer (including invasive and ductal carcinoma in situ) and/or ovarian or fallopian tube or primary peritoneal) cancer; and
  · At least two close blood relatives with breast cancer (at least one with breast cancer at age 50 or younger) and/or ovarian (including) fallopian tube or primary peritoneal cancer

*Family Member*: _____ *Age*: _____(years) *Tumor type:* _____
*Family Member*: _____ *Age*: _____(years) *Tumor type:* _____
*Family Member*: _____ *Age*: _____(years) *Tumor type:* _____

I confirm that this test is medically necessary in accordance with (*Providence Health Plan*) 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 been trained to provide genetic counseling, and that I have conducted a full personal and family history which includes a first, second and third degree pedigree. I confirm that I have provided genetic testing information and pre-test counseling to the patient and they have consented to genetic testing. I have scheduled post-test counseling to review the test results and determine future medical management and treatment plans.

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

Please print name: _____ NPI number: _____

Date of genetic counseling (mm/dd/yy): _____