INVITAE

PROVIDENCE Express Care | at Home

Providence Health Plan Statement of Medical Necessity Form	**Hereditary Arrhythmia Genetic Testing for LongQT Syndrome (LQTS) and Catechoamlinergic Polymorphic Ventricular Tachycardia (CPVT)**
Patient Information	Physician Information
Name:	Physician Name:
Gender: ☐ Male ☐ Female	Tax ID Number:
Providence Health Plan ID Number: ☐ HMO ☐ PPO/ASO	Specialty: ☐ PCP ☐ Specialist ☐ Genetic Counselor (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

NK2, CACNA1C, CALM1, CALM2, CALM3, CAV3, KCNE1, KCNE2, KCNH2, KCNJ2, KCNQ1, SCN5A, TRDN Gene Analysis
CPT Codes (check all that apply):
☑ **81413** (Long QT syndrome gene analyses; full sequence analysis)

ICD-10 Codes (list all applicable codes):

Medical Necessity Criteria

NK2, CACNA1C, CALM1, CALM2, CALM3, CASQ2, CAV3, KCNE1, KCNE2, KCNH2, KCNJ2, KCNQ1, RYR2,SCN5A, TRDN **Mutation Testing:**
Genetic testing for mutations in these genes 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 LQTS or CPVT gene mutation; identify gene and mutation:
_____

☐ Personal history of idiopathic long QT on ECG (resting or stress) or polymorphic ventricular tachycardia on stress ECG;

☐ Personal history of ECG abnormalities associated with LQTS including Torsades de Pointes, T-wave alternans, or notched T-waves in >3 leads

☐ Personal history of unexplained syncope

☐ Personal history of aborted sudden death

☐ Family history of LQTS or CPVT in a first- or second-degree relative, as documented by ECG (resting or stress)
Family Member: _____ *Age*: _____(years)

☐ Family history of LQTS or CPVT in two or more first-, second-, or third-degree relatives, one of whom is a first-degree relative, as documented by ECG (resting or stress)
Family Member: _____ *Age*: _____(years)
Family Member: _____ *Age*: _____(years)

☐ Parent of a child with Sudden Unexplained Death in Infants (SUDI) syndrome

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 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): _____