☐ **Date faxed: _____**

This form MUST be faxed directly to BCBS FEP at 1-855-895-3504 on (or before) the sample collection date. Please include a copy of this form when sending your order/sample to Invitae. The Invitae billing team will follow up with BCBS FEP to ensure coverage. Thank you!

BlueCross® BlueShield®
Federal Employee Program

☐ BCBS FEP Auth Department: Please fax your determination letter directly to Invitae at fax# 510-417-3932.

Prior Authorization Request Form — Genetic Testing for Hereditary Breast and/or Ovarian Cancer

Notice: The Federal Employee Program has a 15 Day turn-around time on all Prior Authorization Requests According to the Blue Cross Blue Shield Service Benefit Plan

Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.

Patient Information

Patient's Name:	Blue Cross Blue Shield ID Number:
Birth Date:	Patient's Phone Number:

Billing Provider Information	Ordering Physician/Provider Information
Name: Invitae Corporation Address: 1400 16th Street San Francisco, CA 94103	☐ Please check this box if the ordering and billing provider are the same Provider's Name: Provider's Address:
Tax ID/NPI Number: NPI: 1316206220	Tax ID/NPI Number:
Office Contact: Patrick Hamm	Office Contact:
Phone: 510-417-3932	Phone:
Fax: 510-417-3932	Fax:

Please enter all codes requested; "by report" codes must have a description of why the code is being used.

ICD-10 CODE(S):

CPT/HCPC CODE(S):

PATIENT CLINICAL INFORMATION

Please provide the following documentation: Anticipated Date(s) of Service: _____

- History and physical and/or consultation notes including:
  - Ethnicity/Ancestry – Ashkenazi Jewish Heritage
  - Personal or family history of cancer (if applicable) including:
    - Family relationship(s): (maternal or paternal), (family member e.g., sibling, aunt, grandparent), (living or deceased) (if applicable)
    - Breast Cancer, Bilateral Breast Cancer, or Ovarian Cancer
    - Site(s) of cancer*
    - Age at diagnosis
    - BRCA1/BRCA2 mutation history (if applicable)
    - Genetic counseling/professional results (if applicable)
- Laboratory or Pathology reports (e.g., BRCA results for BART testing requests, or hormone receptor assay) (if applicable)
- Additionally, for BART Testing (please answer the following):
  Did patient have BRCA testing prior to 2006 when BART testing was not available? ☐ Yes ☐ No
  BRCA1 and BRCA 2 mutation testing results (if available/if applicable) ☐ Positive ☐ Negative

View our Medical Policy on line at http://www.fepblue.org/medical-policies.jsp

Fax Number: 1-855-895-3504	**Phone Number: 1-800-633-4581**

Revised: Effective:

INVITAE

BlueCross® BlueShield®
Federal Employee Program

BCBS Federal Employee Program 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/NPI Number:
BCBS Federal Emoployee Program ID Number:	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

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
- ☐ 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, fallopian tube, or primary peritoneal 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 deleterious founder mutations (e.g., Ashkenazi Jewish 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 (*BCBS FEP*) 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): _____