☐ **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 Colorectal 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 CODE(S):

HCPCS CODE(S):

PATIENT CLINICAL INFORMATION

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

For diagnosis of familial adenomatous polyosis (FAP):

- Age of patient;
- History & Physical to include family history and genetic counseling;
- Operative and pathology reports
- Individuals diagnosed with greater than 20 colonic polyps (proband*).
- Individuals with a family member diagnosed with greater than 20 colonic polyps.
- Is there an affected family member that has been tested?

For diagnosis of hereditary non-polyposis colorectal cancer syndrome:

- Age of patient;
- History & physical to include in-depth family history, relationship of all family members diagnosis with colon cancer, and their age at the time of the diagnosis;
- All previously related clinical documentation, including results of testing for FAP
- Is there an affected family member that has been tested?

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 Colorectal Cancer (Lynch Syndrome)**
Patient Information	Physician Information
Name:	Ordering Provider Name:
Gender: ☐ Male ☐ Female	Tax ID/NPI Number:
BCBS FEP 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 Lynch Syndrome or FAP testing? ☐ Yes ☐ No	

Coding Information

MLH1, MSH2, MSH6, PMS2 CPT Codes:
☑ **81292** (MLH1), **81295** (MSH2), **81298** (MSH6), **81317** (PMS2)

ICD-10 Codes (list all applicable codes):

Medical Necessity Criteria

Mutation Testing: Genetic testing for MLH1, MSH2, MSH6, and/or PMS2 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):

☐ **I am ordering *MLH1, MSH2, MSH6,* and *PMS2* testing and my patient has a personal history of a Lynch-syndrome related cancer (*colorectal, endometrial, ovarian, gastric, pancreas, ureter & renal pelvis, biliary tract, brain (usually glioblastoma), sebaceous gland carcinoma, and small intestine cancer)* or a Lynch-syndrome related benign tumor *(sebaceous gland adenoma or keratoacanthomas)* and meets one of following criteria:**

- ☐ Lynch-syndrome related cancer or tumor was diagnosed at less than 50 years of age
- ☐ Patient has history of two or more Lynch syndrome-associated tumors, regardless of age
- ☐ Patient has one or more first-degree relatives with a Lynch syndrome associated tumor, with one of the tumors being diagnosed under age 50 years
- ☐ Patient has two or more first- or second-degree relatives with Lynch syndrome-associated tumors, regardless of age
- ☐ Patient has first, second or third degree relative with known clinical diagnosis of Lynch syndrome
- ☐ Patient has an MMRPro, PREMM, or MMRpredict model score of 5% or more

If there is colorectal or endometrial tumor available from my patient,
- ☐ the tumor is MSI-H
- ☐ the tumor shows absent MSH2 and/or MSH6 and/or PMS2 protein by IHC
- ☐ Lynch-syndrome related cancer shows absent MLH1 protein in the tumor and the tumor has been shown not to haveMLH1 promoter methylation or not to have a BRAF V600E mutation

☐ **I am ordering *MLH1, MSH2, MSH6, and PMS2* testing. My patient does not have a personal history of a Lynch-syndrome related tumor but meets one of following criteria:**

- ☐ Has one or more first-degree relatives with a Lynch syndrome associated cancer, with one of the cancers being diagnosed under age 50 years
  Family Member: _____ *Age*: _____(years) *Tumor type:* _____
- ☐ Has two or more first- or second-degree relatives with Lynch syndrome-associated cancers, regardless of age
  Family Member: _____ *Age*: _____(years) *Tumor type:* _____
  Family Member: _____ *Age:* _____(years) *Tumor type:* _____
- ☐ Has a first, second or third degree relative with a clinical diagnosis of Lynch syndrome
  Family Member: _____ *Age*: _____(years) *Tumor type:* _____
- ☐ Has an MMRPro, PREMM, or MMRpredict model score of 5% or more

☐ **I am ordering specific *MLH1, MSH2, MSH6, and PMS2* testing for** a known *MLH1, MSH2, MSH6,* or *PMS2* gene mutation first, second or third degree relative.
Family Member: _____ *Identify gene and mutation*: _____

I confirm that this test is medically necessary in accordance with (*BCBS FEP 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): _____