

## **HUSKY Health Program Genetic Testing Prior Authorization Request Form** Phone: 1.800.440.5071

This form MUST be completed and signed by the <u>ORDERING PROVIDER</u> and sent with clinical documentation to the laboratory performing the testing. The laboratory must then fax the form and clinical documentation to 203.265.3994

Member Information							
Member ID #:	DOB:	Member Name (Last, First):					
Address:		City, State, Zip:					
Requested Testing							
Test Name: Date of Service:							
Type of Test (e.g., mutation p	oanel, full gene sequencing, ger	ne panel, deletion/duplication):					
approach/ method is clinical diagnosis.	<u>Note:</u> Requests for testing panels including, but not limited to, multiple genes or multiple conditions, and in cases where a tiered approach/ method is clinically available, are covered only for the number of genes or tests deemed medically necessary to establish a diagnosis.						
Gene mutation being tested t	for:						
Diagnosis (ICD-10 CM) code	(s) to support request for genet	ic testing:					
Please list all CPT codes with	h requested units.						
CPT Code: Units:	CPT Code:	Units: CPT Code:	Units:	-			
CPT Code: Units:	CPT Code:	Units: CPT Code:	Units:	-			
		practice registered nurse (APRN), or certifi of the targeted disease? <i>If no, please expla</i>		□ Yes	□ No		
2. Will genetic counseling be performed prior to and post-testing? <i>If no, please explain:</i>					□ No		
3. Has a specific mutation or reliably associated with the c		ied and broadly accepted by credible medic	al societies to be	□ Yes	□ No		
4. Can the genetic disorder be diagnosed or ruled out through means other than genetic testing (e.g., clinical examination, imaging, laboratory testing, or other testing)? <i>If yes, please describe:</i>					□ No		
5. Has this test been perform	ied previously? <i>If yes, please e</i>	explain why repeat testing is medically ne	cessary:	□ Yes	□ No		
		test is being ordered for the individual? As ines that were used to aid in your of					

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7. List all examina individual. <i>Please</i>		tests, imaging, and d	liagnostic	studies th	nat have been perfo	rmed	as part of the	eva	aluation	of the
Clinical Presenta	tion									
1. Does the individual exhibit clinical features of the mutation in question? If yes, please attach medical record documentation.							□ Yes	□ No		
2. Is the individual	at direct risk of inh	eriting a genetic muta	ation? <i>If ye</i>	s, please	attach medical rec	ord c	locumentation	1.	□ Yes	□ No
3. Is the individual a prospective parent and the fetus would be at high risk for a specific inheritable disease or defect and outcome of testing is required to determine carrier status of inherited disorders and to guide subsequent reproductive decisions? <i>If yes, please attach medical record documentation</i> .							□ Yes	□ No		
History				<u> </u>		-	•			
1. Has less intensi	ve genetic testing	been completed? If ye	es, list pre	vious tes	sting below and atta	ach r	esults.		□ Yes	□ No
Test	D	Date of Testing Muta		Mutatio	ation Identified?		Specific Mutation			
				□ Yes □ No						
					⊐ No					
					□ No					
2. Is there a perso	nal history of this d	liagnosis? <i>If yes, list</i>	history of	related o	liagnoses/disorders	s:			□ Yes	□ No
									res	INU
Diagnosis				Age at	Time of Diagnosis					
3. Is there a famil <b>below.</b>	y history of this d	iagnosis or related di	isorders? I	f yes, lis	t history of related	l dia	gnoses/disord	ers	□ Yes	□ No
Relationship	Maternal/Paterna							amily Mutation If known)?		
		Diagnos								
	□ M □ P				□ Yes □ No		es 🗆 No	۱ ت	′es ⊡ No	)
	□ M □ P				□ Yes □ No	□ Y	es 🗆 No	□ Yes □ No		0
	□ M □ P				□ Yes □ No	□ Y	es 🗆 No	□ Yes □ No		)
					□ Yes □ No	□ Y	es 🗆 No	□ Yes □ No		)
4. Does spouse/reproductive partner have a history of known disorder, related disorder, or family mutation? <i>If yes, please</i>										
describe:					Yes	No				
5. Does a previous child have a history of known disorder, related disorder, or family mutation? If yes, please describe:										
-					2	-			Yes	No
									1	

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1. Will test results have a material impact on the treatment plan and lead to interventions and surveillance beyond what is typically recommended for individuals without the genetic mutation? <i>If yes, please describe</i> :          \bookstate         \bookstate         Yes         \bookstate         \bookstate         Yes         Yes         \book         Yes         Yes         Yes	Medical Management							
2. Will test results improve health outcomes for the individual? If yes, please describe:          \Prove the second test is the individual? If yes, please describe:           \Prove the second test is the individual? If yes, please describe:           \Prove test is the individual? If yes, please describe:           \Prove test is the individual? If yes, please describe:           \Prove test is the individual? If yes, please describe:           \Prove test is the individual? If yes, please describe:           \Prove test is the individual? If yes, please describe:           \Prove test is the individual?          4. Will the change in medical management result in a reduced risk of morbidity and/or mortality?           \Prove test is a conditional individual?           \Provetest is is conditional individual?           \Provetest is conditional individual?           \Provetest is conditional?           \Provetest is conditional individual?           \Provetest is conditional individual?         \Provetest is conditional individual?         \Provetest is conditional information submitted with this request will be considered as part of the medical necessity review process, is conditional information is conditional individual?         \Provetest is conditional information is conditional individual?         \Provetest is conditional?         \Provider Information         \Provetest is co								
3. Is the disease treatable or preventable? If yes, please describe:       Image: Second	typically recommended for individ	Juals without the genetic mutation?	If yes, please describe:	Yes	No			
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Physician Signature: Date:	Physician Signature: Date:							