HUSKY Health Program Oncotype DX® for Breast Cancer
Prior Authorization Request Form
Phone: 1.800.440.5071

THIS FORM IS TO BE COMPLETED BY THE ORDERING PROVIDER AND FAXED WITH CLINICAL DOCUMENTATION TO 203.265.3994

Member Information			
Member ID #:	DOB:	Member Name (Last, First):	
Address:		City, State, Zip:	
Requested Testing			
CPT Code:	ICD-10 CM DX Code(s):	Date of Service:	

1. Is the patient a biological female with newly diagnosed stage I or II invasive breast cancer?	○ Yes	○ No
2. Is the patient a biological female with newly diagnosed ductal carcinoma in situ? ***If yes, please attach supporting clinical information.***	○ Yes	○ No
3. Is the patient a biological male with breast cancer? ***If yes, please attach supporting clinical information.***	○ Yes	○ No
4. If no, to all of the above, please explain reason for Oncotype DX® testing.	☐ N/A	
5. Has Oncotype DX® testing been previously performed on this patient? ***If yes, please explain why retesting is necessary.***	○ Yes	○ No

Clinical Presentation		
1. Is the tumor estrogen receptor-positive or progesterone receptor-positive?	○ Yes	○ No
2. Is the tumor human epidermal growth factor receptor 2 (HER2) negative?	○ Yes	○ No
3. Is the tumor ≥ 0.6 cm to ≤ 1 cm in diameter with unfavorable features? ***Please indicate tumor size:***	○ Yes	○ No
4. Is the tumor > 1 cm in diameter? ***Please indicate tumor size:***	○ Yes	○ No
5. Are lymph node(s) negative?	○ Yes	○ No
6. Do lymph node(s) contain ≤ 2 mm micrometastases only (pN1mi)?	○ Yes	○ No
7. Are lymph node(s) positive? ***Please explain why testing is medically necessary and attach supporting documentation.***	○ Yes	○ No
8. Is the patient a candidate for adjuvant systemic chemotherapy?	○ Yes	○ No
9. Is the test being ordered by the provider that will be administering the hormonal and/or chemotherapy to the patient based on the test results? ***If no, please explain.***	○ Yes	○ No

Additional clinical information relevant to requested testing:

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Note: Review criteria are used as guidelines only. Determinations are based on a person-centered assessment of the individual and their unique clinical needs. Additional information submitted with this request will be considered as part of the medical necessity review process, in accordance with Conn. Gen. Stat. Sec. 17b-259b.		
Billing Provider Information		
Medicaid Billing Number:		Billing Provider Name:
Street Address:		City, State, Zip:
Contact Name:	Contact Telephone Number:	Contact Fax Number:
Ordering Provider Information		
Medicaid Billing Number:		Ordering Provider Name:
Street Address:		City, State, Zip:
Contact Name:	Contact Telephone Number:	Contact Fax Number:
Certification Statement: This is to certify that the requested testing is medically indicated and is reasonable and necessary for the treatment of this patient and that a prescribing practitioner signed order is on file. This form and any statement on my letterhead attached hereto has been completed by me or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil and criminal liability.		
Physician Signature:		**Date:**