# HUSKY Health Program Whole Exome Sequencing and Whole Genome Sequencing Prior Authorization Request Form

**Phone: 1.800.440.5071**

**This form MUST be completed and signed by the ORDERING PROVIDER 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 #: | Member Name (Last, First): | | |
| Address: | City, State, Zip: | | |
| Primary Diagnosis: | DOB: | Age: | |
| Date of Service: | | | |

**Whole Exome Sequencing (WES) – CPT Code 81415** ☐

Please complete the following sections and **submit the patient's clinical summary, relevant medical records, and previous test results.**

| | | | |
|---|---|---|---|
| 1. | Rationale for testing:<br>☐ Unexplained congenital or neurodevelopmental disorder(s)<br>☐ Multiple genetic anomalies<br>☐ Moderate to severe intellectual disability<br>☐ Epilepsy/seizure disorder<br>☐ Other: _____ | | |
| 2. | Please describe congenital anomalies: | ☐ N/A | |
| 3. | Please describe dysmorphic features: | ☐ N/A | |
| 4. | Is WES being ordered for prenatal testing of a fetus?<br>**Note:** WES of a fetus is typically considered investigational and therefore not medically necessary. Requests will be reviewed on an individual basis.<br>***Please attach clinical documentation supporting the medical necessity for this testing.*** | ○ Yes | ○ No |
| 5. | Is WES being ordered by a board-certified medical geneticist or other board-certified physician with specific expertise in clinical genetics? | ○ Yes | ○ No |
| 6. | Has the patient been evaluated and counseled by a board certified medical geneticist or other board-certified physician with expertise in clinical genetics? ***Please attach physician notes.*** | ○ Yes | ○ No |
| 7. | Has other genetic testing been performed and failed to yield a diagnosis? ***Please check all that apply and provide differential diagnosis, comprehensive testing algorithm, and previous test results.***<br>☐ Microarray _____<br>☐ Metabolic testing_____<br>☐ Chromosome/FISH analysis _____<br>☐ Single gene testing _____<br>☐ Targeted panel testing _____<br>☐ Muscle/skin biopsy _____<br>☐ Radiologic studies (MRI, CT scan, X-ray) _____<br>☐ Other: _____ | ○ Yes | ○ No |
| 8. | Is a genetic etiology considered the most likely explanation for the phenotype or clinical scenario of the patient despite previous genetic testing that failed to yield a diagnosis? | ○ Yes | ○ No |
| 9. | Does the clinical picture fit a well-described syndrome? | ○ Yes | ○ No |
| 10. | Can a diagnosis be made by standard clinical work-up (excluding invasive procedures such as muscle biopsy)? | ○ Yes | ○ No |
| 11. | Is there a predicted impact on health outcomes? ***If yes, please attach supporting documentation and check all that apply.***<br>☐ Reducing diagnostic uncertainty (e.g., eliminating lower yield testing and additional screening tests that may later be proved unnecessary once a diagnosis is achieved)<br>☐ Guiding prognosis and improving clinical decision making<br>☐ Application of specific treatments<br>☐ Withholding of contraindicated treatments<br>☐ Surveillance for later-onset comorbidities; or initiation of palliative care; or modification of care | ○ Yes | ○ No |
| 12. | Have other causative circumstances (e.g., environmental exposures, injury, infection) been ruled out? | ○ Yes | ○ No |
| 13. | Will WES testing preclude the need for multiple or invasive procedures? ***If yes, please explain.*** | ○ Yes | ○ No |

**HUSKY Health Program Whole Exome Sequencing and Whole Genome Sequencing Prior Authorization Request Form**
**Phone: 1.800.440.5071**

**This form MUST be completed and signed by the ORDERING PROVIDER 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.**

14. Please draw or attach patient's three generation pedigree.

**WES Comparator (Trio) Testing – CPT Code 81416 □**

| | | |
|---|---|---|
| 1. Has WES testing of the affected patient been completed? ***If yes, please complete above section and attach results.*** | ○ Yes | ○ No |
| 2. Trio testing will be performed on: ***Please check all that apply.***<br>☐ Biological mother<br>☐ Biological father<br>☐ Sibling(s) | | |

**WES Reanalysis – CPT Code 81417 □**

| | | |
|---|---|---|
| 1. Have new gene(s) been reported in the literature that are associated with the patient's phenotype; or have new gene functions been reported in the literature that establish new phenotype-genotype correlations? ***If yes, please describe and attach supporting literature.*** | ○ Yes | ○ No |
| 2. Has there been an onset of new symptoms that broadens the phenotype assessed during the original exome evaluation? ***If yes, please describe and attach supporting documentation.*** | ○ Yes | ○ No |
| 3. Has there been the birth or diagnosis of a similarly affected first-degree relative that has expanded the clinical picture? ***If yes, please attach supporting documentation.*** | ○ Yes | ○ No |

**Whole Genome Sequencing (WGS) – CPT Code □ 81425 □ 81426 □ 81427**

WGS is typically considered investigational and therefore not medically necessary for all indications. Requests for WGS will be reviewed on an individual basis. ***Please attach clinical documentation supporting the medical necessity of WGS.***

**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: |
| Phone #: | Fax #: | Contact Name: |

**Ordering Provider Information**

| | | |
|---|---|---|
| Medicaid Billing Number: | | Ordering Provider Name: |
| Street Address: | | City, State, Zip: |
| Phone #: | Fax #: | Contact Name: |

**Certification Statement:** This is to certify that the requested medication 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:** |