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:		

Requested Test(s)

☐ 81415 ☐ 81416 ☐ 81417 ☐ 81425 ☐ 81426 ☐ 81427

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

1. Rationale for testing:
   - ☐ Unexplained congenital or neurodevelopmental disorder(s)
   - ☐ Epilepsy/seizure disorder
   - ☐ Moderate to severe intellectual disability
   - ☐ Multiple genetic anomalies
   - ☐ Congenital heart disease (specify type) _____
   - ☐ Other _____

Please attach clinical documentation supporting the medical necessity for this testing.

2. Is WES being ordered for prenatal testing of a fetus? ***Please attach clinical documentation supporting the medical necessity for this testing.***	○ Yes	○ No
3. Has other genetic testing been performed? ***Please check all that apply and provide differential diagnosis and previous test results.*** ☐ Microarray ☐ Chromosome/FISH analysis ☐ Single gene testing ☐ Targeted panel testing ☐ Other: _____	○ Yes	○ No
4. Does the clinical picture fit a well-described syndrome?	○ Yes	○ No

If requesting a WES Reanalysis

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

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 test 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:**