GENETIC TESTING SERVICE AUTHORIZATION REQUEST

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 527 (6-2020)

Clear Fields

The following provider information is required to complete the service authorization request:

Procedure Request

Billing Provider Name and NPI - name of the clinic, group, or sole proprietor and associated NPI that will be listed in Box 33 (a) and (b) of the CMS 1500 or electronic equivalent (not the individual rendering provider).

**if the ordering provider is authorizing on behalf of the reference laboratory, the Billing Provider Name and NPI should be the Reference Laboratory

Billing Facility Name and NPI - name of the facility (hospital or ambulatory surgery center) and associated NPI that will be billing for the technical or facility portion of the (where the laboratory testing will be performed).

Modifiers

CPT and HCPCS codes must be requested exactly how they will appear on the claim. All applicable modifiers must be present on the service authorization request. Failure to do so will result in a denial of the claim.

RECIPIENT INFORMATION

Recipient Last Name, First Name, Middle Initial	Recipient Medicaid ID Number	Date of Birth

ICD-10 CM CODES (required)

1)	2)	3)	4)	5)	6)
7)	8)	9)	10)	11)	12)

PROVIDER INFORMATION

Billing Provider Name (see instructions)	Billing Provider NPI	Requested Date of Procedure
Billing Facility Name		Billing Facility NPI

REQUESTING PROVIDER CONTACT

Contact Person Name	Telephone Number	Fax Number	Today's Date

REQUESTED TESTS - all applicable modifiers used for billing must be present on the Service Authorization Request

CPT / HCPCS Code and Applicable Modifiers		1) Code	Mod	2) Code	Mod	3) Code	Mod	4) Code	Mod
5) Code	Mod	6) Code	Mod	7) Code	Mod	8) Code	Mod	9) Code	Mod

**Pharmacogenetic panel tests for therapy selection, such as panel tests for psychotropic, analgesics or ADHD stimulant medications are considered not medically necessary and therefore not covered.

WHAT THERAPIES AND MEDICATIONS ARE CURRENTLY IN PLACE? (Please attach results of all diagnostic testing. For example, labs, biopsy, pathology, x-rays, results of previous genetic testing performed, if any).

How will the outcome of the genetic testing affect the recipient's plan of care if the results are positive or negative? (Please be specific, for example: List medications that will be added or discontinued, specific therapy or procedures needed that will be associated with positive or negative results, or further screening or diagnostic testing that would be needed and has not already been evaluated) .

Indications for BRCA1/BRCA2 Testing - please mark all that apply

- ☐ Personal history of ovarian, fallopian tube, or primary peritoneal cancers
- ☐ Personal history of male breast cancer
- ☐ Individual with a history of breast, ovarian, pancreatic, or prostate cancer from a family with a known BRCA1/BRCA 2 pathogenic or likely pathogenic variant
- Personal history of breast cancer and one or more of the following indications:
  - ☐ Individual of ethnicity associated with higher mutation frequency (e.g. Ashkenazi Jewish)
  - ☐ Diagnosed at age 45 or under
  - Diagnosed at age 50 or under with any of the following:
    - ☐ An additional breast cancer primary
    - ☐ At least one close blood relative with breast cancer at any age
    - ☐ Unknown or limited family history
  - Diagnosed at age 60 or under with a:
    - ☐ Triple negative breast cancer (estrogen receptor (ER) negative, progesterone receptor (PR) negative, and human epidermal growth factor receptor 2 (HER2) negative)
  - Diagnosed at any age with any of the following:
    - ☐ At least one close blood relative with breast cancer diagnosed at age 50 or under
    - ☐ At least two additional diagnoses of breast cancer in the patient and/or close blood relative(s) at any age
    - ☐ At least one close blood relative with ovarian, fallopian tube, or primary peritoneal cancers
    - ☐ At least one close blood relative with pancreatic cancer
    - ☐ At least one close blood relative with prostate cancer (Gleason score ≥7 or metastatic)
    - ☐ At least one close blood relative with male breast cancer
- ☐ Personal history of pancreatic cancer
- Personal history of prostate cancer (Gleason score ≥7) at any with any of the following:
  - ☐ Personal history of prostate cancer (Gleason score ≥7) at any with any of the following:
  - ☐ At least 1 close blood relative with breast cancer at age 50 or under
  - ☐ At least 2 close blood relatives with breast cancer or prostate cancer (any grade)
  - ☐ Ashkenazi Jewish ancestry
- ☐ Personal history of metastatic prostate cancer
- ☐ Individual with a history of breast, ovarian, pancreatic, or prostate cancer and a BRCA1/BRCA2 pathogenic variant detected by tumor profiling on any tumor type in the absence of germline variant analysis
- Personal history of breast, ovarian, pancreatic, or prostate cancer with either of the following:
  - ☐ First- or second-degree blood relative meeting any of the above criteria
  - ☐ Third-degree blood relative who has breast cancer or ovarian/fallopian tube/primary peritoneal cancer and who has at least two close blood relatives with breast cancer (at least one who was diagnosed at age 50 or under) or ovarian/fallopian tube/primary peritoneal cancer

Indications for Lynch Syndrome Testing

- Personal history of a Lynch syndrome related cancer with one of the following:
  - ☐ A known MLH1, MSH2, MSH6, PMS2, or EPCAM pathogenic or likely pathogenic variant in the family
  - ☐ ≥1 first-degree relative with colorectal or endometrial cancer diagnosed under the age of 50
  - ☐ ≥1 first-degree relative with colorectal or endometrial cancer and another synchronous or metachronous Lynch syndrome related cancer
  - ☐ ≥2 first-degree or second-degree relatives with Lynch syndrome related cancers, including ≥1 diagnosed under the age of 50
  - ☐ ≥3 first-degree or second-degree relative with a Lynch syndrome related cancer regardless of age
- Personal history of colorectal or endometrial cancer with one of the following:
  - ☐ Diagnosed under the age of 50
  - ☐ Another synchronous or metachronous Lynch syndrome related cancer
  - ☐ ≥1 first-degree or second-degree relative with a Lynch syndrome related cancer diagnosed under the age of 50
  - ☐ ≥2 first-degree or second-degree relatives with a Lynch syndrome related cancer regardless of age
- ☐ Personal history of colorectal or endometrial cancer at any age with tumor showing evidence of mismatch repair (MMR) deficiency, either by microsatellite instability (MSI) or loss of MMR protein expression
- ☐ Personal history of a colorectal tumor with MSI-high (MSI-H) histology (i.e. presence of tumor-infiltrating lymphocytes, Crohns-like lymphocytic reaction, mucinous/signet ring differentiation, or medullary growth pattern) diagnosed at age 60 or under
- ☐ Personal history of a Lynch syndrome related cancer who has a ≥5% risk of having a Lynch syndrome mutation based on the MMRpro or MMRpredict models, or ≥2.5% risk of having a Lynch syndrome mutation based on the PREMM5 model

*Lynch syndrome related cancers include colorectal, endometrial, ovarian, gastric, pancreas, ureter, and renal pelvis, biliary tract, brain (usually glioblastoma), small intestine cancers, as well as sebaceous gland adenomas/carcinomas and keratoacanthomas.

☐ I certify that the information given in this form is a true and accurate medical indication for the procedure(s) required.

Provider Signature (Required)	Date

REMARKS (state use only)

☐ Approve	Start Date	End Date	Clinical SA Number	Facility SA Number
☐ Deny	Reason			
☐ Pending	Reason			
Comments				
Signature of Reviewer				

Prior authorization does not guarantee payment for the services; payment is contingent upon passing all edits contained within the claims payment process, the recipients continued Medicaid eligibility, the providers's continued Medicaid eligibility, and ongoing medical necessity for the services.

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