Hereditary Breast and Ovarian Cancer (HBOC) Genetic Testing Prior Authorization Form: Beneficiary Informed Consent for Hereditary Cancer Genetic Testing

Instructions: Prior authorization request for BRCA 1 and BRCA 2 genes and BRCA Analysis Rearrangement testing for breast and ovarian cancer must be submitted to Acentra Health. The Hereditary Breast and Ovarian Cancer Genetic Testing Prior Authorization Form must be completed and signed as outlined in the instructions below. The completed form with the original dated signature must be retained by the requesting physician in the beneficiary's medical record. The form is subject to retrospective review.

The following forms, documents, and information must be submitted with the prior authorization request to Acentra Health:

- ☐ The completed and signed Hereditary Breast and Ovarian Cancer Genetic Testing Prior Authorization Form
- ☐ Medical necessity documentation, including documentation of the efforts made to obtain the test results of previous comprehensive sequencing when appropriate
- ☐ Attestation for comprehensive testing. The attestation must indicate that familial BRCA testing results could not be obtained (as necessary).

Providers can refer to the South Carolina Department of Health and Human Services Physician Services Guide on the website at www.scdhhs.gov for specific information about coverage guidelines, prior authorization requirements and billing guidance.

Hereditary Breast and Ovarian Cancer (HBOC) Genetic Testing Prior Authorization Form: Beneficiary Informed Consent for Hereditary Cancer Genetic Testing

Section A: Beneficiary Information	
Name:	
Medicaid ID#:	Date of birth:

Section B: Requested procedure or service information

Check one:

☐ This request is for initial BRCA 1 and BRCA 2 testing.

☐ This request is for repeat BRCA 1 and BRCA 2 comprehensive sequencing testing because initial results are negative, or are not available, and large rearrangement testing is necessary. **Note:** The physician must make every reasonable effort to obtain from the previous physician any available BRCA 1 and BRCA 2 test results for the beneficiary and must submit documentation of the efforts made to obtain the test results of previous comprehensive sequencing to Acentra Health with the prior authorization request.

Expected dates of service **From:** **To:**

Procedure code requested	**Procedure code description**

Comments:

Section C: Medical necessity information – Submit clinical notes to support genetic testing request.

Diagnosis code(s):

Medical necessity:

Information about close blood relatives from the same side of the family who have been diagnosed with ovarian, breast, prostate (Gleason score of 7 or greater), or pancreatic cancer, or who have had a positive BRCA1 or BRCA2 test results with no diagnosis of cancer:

Relative	a. Age	b. Gender	c. Cancer	d. Relationship to Beneficiary	e. Positive BRCA1 or BRCA2 Results
Relative #1:					
Relative #2:					
Relative #3:					
Relative #4:					

For full sequence or gene variants: Positive familial BRCA testing results could not be obtained	☐ Yes ☐ No

Ethnic decent of beneficiary if associated with deleterious mutations (including, but not limited to: Ashkenazi Jewish, Icelandic Swedish, or Hungarian):

Physician's name:

Telephone number:	Fax number:
Physician's NPI:	Facility/Office NPI:
Physician's signature:	Date signed:

Hereditary Breast and Ovarian Cancer (HBOC) Genetic Testing Prior Authorization Form: Beneficiary Informed Consent for Hereditary Cancer Genetic Testing

Section D: Requirements for genetic counseling and beneficiary consent – The beneficiary must receive pre-testing genetic counseling and provide consent for genetic testing before the prior authorization is submitted and the blood specimen is obtained. Documentation of the genetic counseling must be maintained in the beneficiary's medical record.	
Date the beneficiary receive pre-testing genetic counseling:	
Name of person who provided pre-testing genetic counseling:	
Qualifications of person providing pre-testing genetic counseling:	
Counselor telephone number:	Counselor fax number:
Date beneficiary's consent was obtained for the genetic testing:	
Section E: Laboratory provider information	
Provider name:	
Address/City/Zip	
Contact person:	
Telephone number:	Fax number:
NPI:	Tax ID: