GENETIC TESTING FOR HERITABLE CONDITIONS PRIOR AUTHORIZATION FORM

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This form must be completed by a person with thorough clinical knowledge of the member's current clinical presentation and his/her clinical evaluation history. **Clinical documentation supporting the medical necessity of this request is required (include the AHCP Order for genetic testing).** For more information, please refer to the medical policy document MP/G001 Genetic Testing for Heritable Conditions located at https://www.preferredone.com/MedicalPolicy/.

Please email this form and clinical documentation to Intake@Preferredone.com or fax to (763) 847-4014.

Patient Name	**PreferredOne ID #**		**DOB**
ICD 10 DX	**Ordering Provider Signature**		**Procedure Code(s)**
Date of Service	**Date of Lab Draw**		
Ordering Provider First & Last Name			**NPI #**
Clinic Name			**NPI #**
Address			**City**
Phone	**Fax**	**State**	**Zip**
Servicing Provider Name (Lab)			**NPI #**
Address			**City**
Phone	**Fax**	**State**	**Zip**

LIST GENE(S) BEING TESTED:
LIST DISEASE/SICKNESS/DEFECT BEING TESTED FOR:

REQUESTS FOR GENETIC TESTING MUST MEET ONE OF THE FOLLOWING	**Check Box**
Member displays clinical features of a specific inheritable disease/sickness/defect.	☐
Member does not display clinical features of a specific inheritable disease/sickness/defect, but is at direct risk of inheriting the mutation in question.	☐
MUST ALSO HAVE ALL OF THE FOLLOWING (Check all that apply):	**Check Box**
Genetic testing is ordered after a history, physical examination, and completion of conventional diagnostic studies, and a definitive diagnosis remains uncertain. Please list testing/results:	☐
A genetic counselor, medical geneticist, or other health care professional trained in genetics, independent of the laboratory performing the testing, has reviewed and documented the family history, created a pedigree, and obtained informed consent.	☐
The inheritable disease/sickness/defect is associated with the gene being tested.	☐

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HOW WILL THE RESULT OF THIS TEST DIRECTLY IMPACT THE CURRENT TREATMENT OR MANAGEMENT BEING DELIVERED TO THE MEMBER? (Check all that apply):	**Check Box**
Guiding surveillance for complications – please explain:	☐
Employing risk reduction strategies – please explain:	☐
Determining avenues of therapy – please explain:	☐
Other:	☐
ANY OF THE FOLLOWING, AS APPLICABLE (Check all that apply):	**Check Box**
There is a known familial variant (ie, the location of the mutation is known)	☐
Request is for multi-gene testing (hereditary panels) (must have all of the following) ☐ All genes included on the multi-gene test are clinically actionable ☐ Testing will target the gene variant with the highest disease-causing penetrance first (for testing panels including but not limited to multiple genes or multiple conditions, and in cases where a tiered approach/method is clinically available) ☐ The member's personal and/or family history is suggestive of an inherited syndrome that can be explained by more than one gene mutation.	☐
Request is for comprehensive genetic analysis on multiple family members	☐