

## HUSKY Health Program Genetic Testing

### Prior Authorization Request Form

Phone: 1.800.440.5071

**This Form MUST be completed and signed by the ORDERING PROVIDER and faxed with clinical documentation to 203.265.3994**

Member Information			
Member ID #:	DOB:	Member Name (Last, First):	
Address:		City, State, Zip:	
Requested Testing			
Test Name:			
Type of Test (e.g., mutation panel, full gene sequencing, gene panel, deletion/duplication):			
<i>Note:</i> Requests for testing panels including, but not limited to, multiple genes or multiple conditions, and in cases where a tiered approach/ method is clinically available, are covered only for the number of genes or tests deemed medically necessary to establish a diagnosis.			
Gene mutation being tested for:			
Diagnosis (ICD-10 CM) code(s) to support request for genetic testing:			
Please list all CPT codes with requested units.			
CPT Code: _____	Units: _____	CPT Code: _____	Units: _____
CPT Code: _____	Units: _____	CPT Code: _____	Units: _____
1. Is the testing being ordered by a board certified medical geneticist or other board certified physician with specific expertise in clinical genetics who is not affiliated with the testing laboratory?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
2. Has the individual been evaluated and counseled by a board certified medical geneticist or other board certified physician with specific expertise in clinical genetics who is not affiliated with the testing laboratory? <b><i>Please attach three generation pedigree and documentation from the medical record.</i></b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
3. Has a specific mutation or set of mutations been identified and broadly accepted by credible medical societies to be reliably associated with the condition or defect?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
4. Can the genetic disorder be diagnosed or ruled out through means other than genetic testing (e.g. clinical examination, imaging, laboratory testing, or other testing)? <b><i>If yes, please explain why the requested test is medically necessary.</i></b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Clinical Presentation			
1. Does the individual exhibit clinical features of the mutation in question? <b><i>If yes, please attach medical record documentation.</i></b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
2. Is the individual at direct risk of inheriting a genetic mutation? <b><i>If yes, please attach medical record documentation.</i></b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
3. Is the individual a prospective parent and the fetus would be at high risk for a specific inheritable disease or defect and outcome of testing is required to determine carrier status of inherited disorders and to guide subsequent reproductive decisions? <b><i>If yes, please attach medical record documentation.</i></b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
History			
1. Has less intensive testing been completed? <b><i>If yes, list previous testing and attach results:</i></b>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Test	Date of Testing	Mutation Identified?	Specific Mutation Identified
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Is there a personal history of this diagnosis? <b><i>If yes, list history of related diagnoses/disorders:</i></b>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Diagnosis	Age at Time of Diagnosis		
3. Is there a family history of this diagnosis or related disorders? <b><i>If yes, list history of related diagnoses/disorders on next page:</i></b>			<input type="checkbox"/> Yes <input type="checkbox"/> No

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Relationship	Maternal/Paternal	Diagnosis	Age at Time of Diagnosis	Family Member Deceased?	Was Genetic Testing Completed?	Family Mutation (If known)?	
	<input type="checkbox"/> M <input type="checkbox"/> P			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> M <input type="checkbox"/> P			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> M <input type="checkbox"/> P			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> M <input type="checkbox"/> P			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Does spouse/reproductive partner have a history of known family mutation, disorder, or related disorder? <i><b>If yes, please describe:</b></i>						<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Does a previous child have a history of known disorder, related disorder or family mutation? <i><b>If yes, please describe:</b></i>						<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Medical Management</b>							
1. Will test results directly impact the medical management of the individual?						<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Is the disease treatable or preventable? <i><b>If yes, please describe:</b></i>						<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Will the results change the frequency, intensity, or type of surveillance or treatment of the condition? <i><b>If yes, please describe:</b></i>						<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Will the results determine avenues of therapy? <i><b>If yes, please describe:</b></i>						<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Will the change in medical management result in a reduced risk of morbidity and/or mortality?						<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Will the testing avoid or supplant additional testing? <i><b>If yes, please describe:</b></i>						<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Note:</b> 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.							
<b>Billing Provider Information</b>							
Medicaid Billing Number:				Billing Provider Name:			
Street Address:				City, State, Zip:			
Phone #:		Fax #:		Contact Name:			
<b>Ordering Provider Information</b>							
Medicaid Billing Number:				Ordering Provider Name:			
Street Address:				City, State, Zip:			
Phone #:		Fax #:		Contact Name:			
<b>Certification Statement:</b> This is to certify that the requested testing 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.							
<b>Physician Signature:</b>				<b>Date:</b>			