



## 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 faxed with clinical documentation to **203.265.3994**

Member Information			
Member ID #:	Member Name (Last, First):		
Address:	City, State, Zip:		
Primary Diagnosis:	DOB:	Age:	
Whole Exome Sequencing (WES) <input type="checkbox"/>			
1. Is WES being ordered to evaluate for unexplained congenital or neurodevelopmental disorders? <b><i>If yes, please attach supporting documentation.</i></b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
2. Is WES being ordered for prenatal testing of a fetus for congenital disorders during the second or third trimester? <b><i>If yes, please attach supporting documentation.</i></b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
3. Is WES being ordered by a board certified medical geneticist or other board certified physician with specific expertise in clinical genetics?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
4. Has the patient been evaluated and counseled by a board certified medical geneticist or other board certified physician with expertise in clinical genetics? <b><i>Please attach three generation pedigree and physician notes.</i></b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
5. Has other genetic testing been performed? <b><i>If yes, please attach results.</i></b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
6. Is a genetic etiology considered the most likely explanation for the phenotype or clinical scenario of the patient despite previous genetic testing that failed to yield a diagnosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
7. Will the WES results directly impact clinical decision making? <b><i>Please attach documentation outlining how WES results will impact clinical decision making.</i></b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
8. Have other causative circumstances (e.g. environmental exposures, injury, infection) been ruled out?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
9. Will WES testing preclude the need for multiple or invasive procedures?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
10. Does this request pertain to repeat analysis of existing exome data for a patient with a new diagnosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Whole Genome Sequencing (WGS) <input type="checkbox"/>			
WGS is typically considered investigational and therefore not medically necessary for all indications. Requests for WGS will be reviewed on an individual basis. <b><i>Please attach clinical documentation supporting the medical necessity of WGS.</i></b>			
*Test Selection – Use of this Prior Authorization Form is limited to the CPT codes listed below.			
<input type="checkbox"/> Exome; sequence analysis (81415)	<input type="checkbox"/> Genome; sequence analysis (81425)		
<input type="checkbox"/> Exome; sequence analysis, each comparator exome (81416)	<input type="checkbox"/> Genome; sequence analysis, each comparator genome (81426)		
<input type="checkbox"/> Exome; re-evaluation of previously obtained exome sequence (81417)			
<input type="checkbox"/> Genome; re-evaluation of previously obtained genome sequence (81427)			
<input type="checkbox"/> Molecular pathology procedure level 9 (81408) Number of Units: _____			
<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.			
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:	
<b>Certification Statement:</b> 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.			
<b>Physician Signature:</b>	<b>Date:</b>		