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 sent with clinical documentation to the laboratory performing the testing. The laboratory must then fax the form and clinical documentation to 203.265.3994

Member Information		
Member ID #:	DOB:	Member Name (Last, First):
Address:		City, State, Zip:

Requested Testing	
Test Name:	Date of Service:
Type of Test (e.g., mutation panel, full gene sequencing, gene panel, deletion/duplication):	
Note: 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: _____ 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?	◯ Yes	◯ 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? ***Please attach three generation pedigree and documentation from the medical record.***	◯ Yes	◯ 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?	◯ Yes	◯ 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)? ***If yes, please explain why the requested test is medically necessary.***	◯ Yes	◯ No

Clinical Presentation		
1. Does the individual exhibit clinical features of the mutation in question? ***If yes, please attach medical record documentation***.	◯ Yes	◯ No
2. Is the individual at direct risk of inheriting a genetic mutation? ***If yes, please attach medical record documentation***.	◯ Yes	◯ 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? ***If yes, please attach medical record documentation***.	◯ Yes	◯ No

History		
1. Has less intensive testing been completed? ***If yes, list previous testing and attach results:***	◯ Yes	◯ No

Test	Date of Testing	Mutation Identified?	Specific Mutation Identified
		◯Yes ◯No	
		◯Yes ◯No	
		◯Yes ◯No	

2. Is there a personal history of this diagnosis? ***If yes, list history of related diagnoses/disorders:***	◯ Yes	◯ No

Diagnosis	Age at Time of Diagnosis

3. Is there a family history of this diagnosis or related disorders? ***If yes, list history of related diagnoses/disorders on next page:***	◯ Yes	◯ 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)?
	◯M ◯P			◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
	◯M ◯P			◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
	◯M ◯P			◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
	◯M ◯P			◯Yes ◯No	◯Yes ◯No	◯Yes ◯No

4. Does spouse/reproductive partner have a history of known family mutation, disorder, or related disorder? ***If yes, please describe:***	◯ Yes	◯ No
5. Does a previous child have a history of known disorder, related disorder or family mutation? ***If yes, please describe:***	◯ Yes	◯ No

Medical Management

1. Will test results directly impact the medical management of the individual?	◯ Yes	◯ No
2. Is the disease treatable or preventable? ***If yes, please describe:***	◯ Yes	◯ No
3. Will the results change the frequency, intensity, or type of surveillance or treatment of the condition? ***If yes, please describe:***	◯ Yes	◯ No
4. Will the results determine avenues of therapy? ***If yes, please describe:***	◯ Yes	◯ No
5. Will the change in medical management result in a reduced risk of morbidity and/or mortality?	◯ Yes	◯ No
6. Will the testing avoid or supplant additional testing? ***If yes, please describe:***	◯ Yes	◯ No

Note: 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:

Certification Statement: 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.

Physician Signature:	**Date:**