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 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 #:	Member Name (Last, First):	
Address:	City, State, Zip:	
Primary Diagnosis:	DOB:	Age:
Date of Service:		

Whole Exome Sequencing (WES) ☐

1.	Is WES being ordered to evaluate for unexplained congenital or neurodevelopmental disorders? ***If yes, please attach supporting documentation.***	☐ Yes	☐ No
2.	Is WES being ordered for prenatal testing of a fetus for congenital disorders during the second or third trimester? ***If yes, please attach supporting documentation.***	☐ Yes	☐ No
3.	Is WES being ordered by a board certified medical geneticist or other board certified physician with specific expertise in clinical genetics?	☐ Yes	☐ 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? ***Please attach three generation pedigree and physician notes.***	☐ Yes	☐ No
5.	Has other genetic testing been performed? ***If yes, please attach results.***	☐ Yes	☐ 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?	☐ Yes	☐ No
7.	Will the WES results directly impact clinical decision making? ***Please attach documentation outlining how WES results will impact clinical decision making.***	☐ Yes	☐ No
8.	Have other causative circumstances (e.g. environmental exposures, injury, infection) been ruled out?	☐ Yes	☐ No
9.	Will WES testing preclude the need for multiple or invasive procedures?	☐ Yes	☐ No
10.	Does this request pertain to repeat analysis of existing exome data for a patient with a new diagnosis?	☐ Yes	☐ No

Whole Genome Sequencing (WGS) ☐

WGS is typically considered investigational and therefore not medically necessary for all indications. Requests for WGS will be reviewed on an individual basis. ***Please attach clinical documentation supporting the medical necessity of WGS.***

***Test Selection – Use of this Prior Authorization Form is limited to the CPT codes listed below.**

☐Exome; sequence analysis (81415)

☐Genome; sequence analysis (81425)

☐Exome; sequence analysis, each comparator exome (81416)

☐Genome; sequence analysis, each comparator genome (81426)

☐Exome; re-evaluation of previously obtained exome sequence (81417)

☐Genome; re-evaluation of previously obtained genome sequence (81427)

☐Molecular pathology procedure level 9 (81408) Number of Units: _______

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 medication 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:**