GENETIC TESTING PRIOR AUTHORIZATION REQUEST FORM

DO NOT USE THIS FORM FOR HEALTH CHOICE UTAH, MOLINA, HEALTHY U OR SELECT HEALTH REQUESTS

MEMBER INFORMATION

MEMBER NAME:		FAX THIS COMPLETED FORM AND ALL REQUIRED SUPPORTING DOCUMENTATION TO: (801) 536-0958 OR MAIL TO: PO BOX 143111 SALT LAKE CITY, UT 84114-3111 FOR QUESTIONS REGARDING GENETIC TESTING PRIOR AUTHORIZATONS, PLEASE CALL: (801) 538-6155 OPTIONS 3, 3, 1
MEMBER ID #:		
DOB:	AGE:	
DATE:	DATE(S) OF SERVICE REQUESTED:	
IS THIS A RETROACTIVE REQUEST? ☐ YES ☐ NO (If yes, reason for retroactive request is required) _____		
NUMBER OF PAGES INCLUDED WITH REQUEST:_____		

PROVIDER INFORMATION

NAME, ADDRESS AND NPI # FOR REQUESTING PROVIDER	NAME, ADDRESS AND NPI # FOR LABORATORY
Name: _____	Name: _____
Address: _____	Address: _____
_____	_____
Phone: (____) _____Fax: (____)_____	Phone: (____) _____Fax: (____)_____
Contact Name: _____	Contact Name: _____
NPI #: _____	NPI #: _____

REQUIRED CLINICAL INFORMATION

ICD-10 CM CODE(S):	DIAGNOSIS CODE DESCRIPTION
1)	
2)	
3)	
HCPCS CODE:	HCPCS CODE DESCRIPTION
1)	
2)	
3)	
GENE(S) TO BE TESTED (IF NOT IDENTIFIED WITH HCPCS CODE):	

UTAH DEPARTMENT OF HEALTH

TYPE OF TEST(S) (E.G., Mutation panel, Full gene sequencing, Gene panel, DEL/DUP):
DESCRIBE THE CLINICAL VALIDITY OF THE TEST(S) (e.g. analytic validity, sensitivity, specificity, positive and negative predictive value):
DESCRIBE THE CLINICAL UTILITY:
DOES THE PATIENT EXHIBIT CLINICAL/PHYSICAL FEATURES ASSOCIATED WITH THE MUTATION IN QUESTION? ☐ YES ☐ NO IF YES, PLEASE SPECIFY:
RELEVANT FAMILY HISTORY:
DESCRIBE CLINICAL FINDINGS FOR THIS PATIENT:
DESCRIBE PAST TREATMENTS THAT HAVE BEEN PROVIDED:
DESCRIBE PREVIOUS TEST RESULTS THAT SUPPORT NEED FOR THIS GENETIC TEST:
DESCRIBE CURRENT TREATMENT PLAN:

HOW WILL KNOWLEDGE OF THE PRESENCE OF THE GENETIC DEFECT CHANGE THE CURRENT TREATMENT AND WHY:

Medical Management:

Medical Interventions:

Monitoring and Screening:

Medication Management:

Other:

PHYSICIAN SIGNATURE: _____ DATE: _____