

Prior Authorization Request Form

(Please choose the appropriate policy for this request)

- ☐ Genetic Testing for BRCA1 or BRCA2 for Hereditary Breast/Ovarian Cancer Syndrome and Other High-Risk Cancers
- ☐ Moderate Penetrance Variants Associated with Breast Cancer in Individuals at High Breast Cancer Risk

BSC Fax: (844) 807-8997

BSC Mail: P.O. Box 629005
El Dorado Hills, CA 95762-9005

Use AuthAccel - Blue Shield's online authorization system - to complete, submit, attach documentation, track status, and receive determinations for both medical and pharmacy authorizations. Visit Provider Connection (www.blueshieldca.com/provider) and click the Authorizations tab to get started.

Notice: BSC has a 5 Business Day turn-around time on all Prior Authorization Requests.
Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.

Provider Information	Patient Information
Servicing Provider/Vendor/Lab's Name and Address:	Patient's Name:
Tax ID Number: NPI:	Birth Date:
Referring/Prescribing Physician's Name:	Blue Shield ID Number:
<input type="checkbox"/> PCP; <input type="checkbox"/> Specialist: PLEASE IDENTIFY SPECIALTY	
Servicing Facility Name and Address:	Place of Service: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Freestanding Ambulatory Surgery Center <input type="checkbox"/> Patient's Home <input type="checkbox"/> Home Care Agency <input type="checkbox"/> Outpatient Hospital Care <input type="checkbox"/> Long Term Care <input type="checkbox"/> Inpatient Hospital Care <input type="checkbox"/> Other (explain): _____
Tax ID Number: NPI:	
Office Contact:	
Phone: ()	
Fax: ()	Anticipated Date of Service:
Please enter all codes requested; "by report" codes must have a description of why the code is being used	
ICD-10 CODE(S):	
CPT CODE(S):	
HCPCS CODE(S):	
PATIENT CLINICAL INFORMATION	
<input type="checkbox"/> Genetic Testing for BRCA1 or BRCA2 for Hereditary Breast/Ovarian Cancer Syndrome and Other High-Risk Cancers Please provide the following documentation: <ul style="list-style-type: none"> History and physical and/or consultation notes including: <ul style="list-style-type: none"> Ethnicity/Ancestry Personal and/or family history of cancer (if applicable) including: <ul style="list-style-type: none"> Family relationship(s): (maternal or paternal), (family member [e.g., sibling, aunt, grandparent]), (living or deceased) ((if applicable)) 	

For questions: Call BSC Medical Care Solutions

Phone Number: 1-800-541-6652 Option 6

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- Site(s) of cancer
- Age at diagnosis (including family members)
- If breast cancer, indicate if bilateral, premenopausal, or triple negative cancer
- BRCA1/BRCA2 mutation history (if applicable)
- Genetic counseling/professional results (if applicable)
- Laboratory or Pathology reports

PATIENT CLINICAL INFORMATION

☐ **Moderate Penetrance Variants Associated with Breast Cancer in Individuals at High Breast Cancer Risk**

Please provide the following documentation:

- History and physical and/or consultation notes including:
 - Ethnicity/Ancestry
 - Personal and/or family history of cancer (if applicable) including:
 - Family relationship(s): (maternal or paternal), (family member [e.g., sibling, aunt, grandparent]), (living or deceased) ((if applicable)
 - Site(s) of cancer
 - Age at diagnosis (including family members)
 - If breast cancer, indicate if bilateral, premenopausal, or triple negative cancer
 - BRCA1/BRCA2 mutation history, multiple primaries, or ovarian cancer, because that individual has the highest likelihood for a positive test result (if applicable)
- Genetic counseling/professional results (if applicable)
- Laboratory or Pathology reports (e.g., BRCA results for BART testing requests, or hormone receptor assay) (if applicable)
- Other pertinent multidisciplinary notes/reports: (e.g., psychological or psychiatric evaluation, physical therapy, multidisciplinary pain management) when applicable

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