blue of california

Prior Authorization Request Form

(Please choose the appropriate policy for this request)

☐ **Genetic Testing for Lynch Syndrome and Other Inherited Colon Cancer Syndromes**

☐ **Genetic Testing for Predisposition to Inherited Hypertrophic Cardiomyopathy**

☐ **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: **Tax ID Number:** **NPI:**	**Patient's Name:** **Birth Date:**
Referring/Prescribing Physician's Name: ☐ **PCP;** ☐ **Specialist:** **PLEASE IDENTIFY SPECIALTY**	**Blue Shield ID Number:**
Servicing Facility Name and Address: **Tax ID Number:** **NPI:**	**Place of Service:** ☐**Physician's Office** ☐**Freestanding Ambulatory Surgery Center** ☐**Patient's Home** ☐**Home Care Agency** ☐**Outpatient Hospital Care** ☐**Long Term Care** ☐**Inpatient Hospital Care** ☐**Other (explain):** _____
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

☐ **Genetic Testing for Lynch Syndrome and Other Inherited Colon Cancer Syndromes**

Please provide the following documentation:

- History and physical and/or consultation notes including:
  - Laboratory invoice/order indicating specific test(s)/panel(s) and associated procedure codes
  - Personal and/or family history of cancer (if applicable) including: family relationship, cancer site(s), age at diagnosis
  - Preliminary diagnosis and prognosis

For questions: Call BSC Medical Care Solutions	**Phone Number: 1-800-541-6652 Option 6**

- Specific test(s) requested and clinical reason/justification for testing
- Treatment plan
- Genetic counseling/professional results (if available)
- Laboratory and/or Pathology report(s) (e.g., APC gene mutations, MSH2, MMR mutations)

PATIENT CLINICAL INFORMATION

☐ Genetic Testing for Predisposition to Inherited Hypertrophic Cardiomyopathy

Please provide the following documentation:

- History and physical and/or consultation notes including:
  - Clinical findings (i.e., pertinent symptoms and duration)
  - Comorbidities
  - Activity and functional limitations
  - Family history if applicable
  - Reason for procedure/test/device, when applicable
  - Pertinent past procedural and surgical history
  - Past and present diagnostic testing and results
  - Prior conservative treatments, duration, and response
  - Treatment plan (i.e., surgical intervention)
- Consultation and medical clearance report(s), when applicable
- Radiology report(s) and interpretation (i.e., MRI, CT, discogram)
- Laboratory results
- Other pertinent multidisciplinary notes/reports: (e.g., psychological or psychiatric evaluation, physical therapy, multidisciplinary pain management) when applicable

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