BlueCross BlueShield
Federal Employee Program

Prior Authorization Request Form	Genetic Testing for Hereditary Breast and/or Ovarian Cancer

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: The Federal Employee Program has a 15 Day turn-around time on all Prior Authorization Requests according to the Blue Cross Blue Shield Service Benefit Plan. 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: ( )	**Anticipated Date of Service:**
Fax: ( )	**Draw Date:**
ICD-10 CODE(S):	
CPT CODE(S): Choose One ☐ 81162 ☐ 81163 ☐ 81164 ☐ 81212 ☐ Other	

Patient Clinical Information

BRCA1 and BRCA2 Mutation Testing: Genetic testing for BRCA1 and BRCA2 mutations in adults (at least 18 years of age or older) may be considered medically necessary when any of the following criteria are met (please check all applicable boxes):

☐ Individual (male or female) from a family with a known deleterious BRCA1/BRCA2 mutation
List mutation (Identify gene): _____
☐ Personal history of breast cancer
☐ Personal history of ovarian cancer
☐ Personal history of fallopian tube cancer
☐ Personal history of pancreatic cancer
☐ Personal history of peritoneal cancer
☐ Personal history of prostate cancer
☐ Is Member of Ashkenazi Jewish Descent? ☐ Yes ☐ No

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☐ An adult without a personal history, but with a family history only of a:
(Complete section below)

First degree blood relative meeting any of the above criteria: First degree relatives are defined as: parents, siblings, and children of the member being tested. Relatives may be living or deceased.

Family Relationship	Age Diagnosed	Male/ Female	Type of Cancer

Second-degree blood relative meeting any of the above criteria: Second degree relatives are defined as: grandparents, aunts, uncles, nieces, nephews, grandchildren, and half-siblings (siblings with one shared biological parent of the member being tested).

Family Relationship	Age Diagnosed	Male/ Female	Type of Cancer

I confirm that I have been trained to provide genetic counseling, and that I have conducted a full personal and family history which includes a first, second and third degree. I confirm that I have provided genetic testing information and pre-test counseling to the patient and they have consented to genetic testing. I have scheduled post-test counseling to review the test results and determine future medical management and treatment plans.

Date genetic counseling completed (mm/dd/yy): _____

If the Provider is the same as the ordering provider, then Check this box. ☐
If other than the ordering provider, please print the Name of Provider Completing the genetic counseling below:

_____

(Attach copy of genetic counseling notes or summary, if not ordering provider.)

I confirm that this test is medically necessary in accordance with BCBSA FEP medical policy and that the information provided is accurate and factual based on the patient's medical records and history. I confirm that this test is medically necessary for the risk and assessment, diagnosis or detection of a disease, illness, impairment, symptom, syndrome or disorder. The results will determine my patient's medical management and treatment decisions.

Ordering Provider Signature: _____ **Date (mm/dd/yy):** _____

Fax Number: 1-855-895-3504 | **Phone Number: 1-800-633-4581**