ASPIRUS HEALTH PLAN

Reset Form

Prior Authorization Genetic Testing Form

FYI ***Incomplete, illegible or inaccurate forms will be returned to sender.*** Please complete the entire form.

Fax form and any relevant clinical documentation to:
Clinical Intake at **715-787-7317**

For questions, **call** Customer Services at:
715-631-7443 or **855-931-5265**

PATIENT INFORMATION

Member Name _____ Member ID _____

Member Address _____ PMI _____

Member City, State, Zip _____ Date of Birth _____

Member Phone _____ Gender: ○ Female ○ Male

ICD-10 _____

ORDERING PROVIDER INFORMATION

Ordering Provider Name _____ ID/NPI Number _____

Ordering Provider Address _____

Ordering Provider City, State, Zip _____

Ordering Provider Phone _____ Fax _____

SERVICE PROVIDER INFORMATION

Service Provider Name _____ ID/NPI Number _____

Service Provider Contact Person _____

Service Provider Address _____

Service Provider City, State, Zip _____

Service Provider Phone _____ Fax _____

ADMINISTRATIVE INFORMATION

◉ Standard Request
Standard review timeframe for an authorization decision is within 14 calendar days or 10 business days from the date the request was received, as expeditiously as the member's health condition requires.

○ Expedited Request
Expedited review timeframe for urgent/emergent requests within 72 hours, as expeditiously as the member's health condition requires. **Only request an expedited review if waiting the standard review timeframe would potentially jeopardize the member's health, life or ability to regain maximum function. Billing and retro authorizations are not expedited.**

Service Item Requested _____ Dates of Service _____

Codes Requested _____

Request Sent By _____ Phone _____

Total Pages Faxed _____

Prior Authorization – Genetic Testing Form (continued)

CRITERIA FOR GENETIC TESTING

Select all that apply:

☐ A personal or family medical history suggests a genetic mutation that increases the risk of a given medical condition.

☐ There is documentation (please include) that knowledge of the test results will directly impact the medical management of the patient because:
- The disease is treatable and/or preventable
- The results will change the frequency, intensity or type of surveillance or treatment of the condition
- The change in medical management is highly likely to result in a reduced risk of morbidity and/or mortality

☐ Testing recommendations are in accordance with existing guidelines (e.g. NCCN, ACMG, ACOG, Medicare, Medicaid).

☐ The testing is FDA/CLIA approved.

☐ The testing has been shown to be clinically valid by peer-reviewed literature (e.g. Hayes® criteria).

☐ The patient has not had prior genetic testing for the same disease/condition (In general, genetic testing should only be performed once in a lifetime).

Confirm and complete the <u>required steps</u> to proceed:

☐ The person ordering the test is also the provider who will be using the results to manage the patient.

☐ **Clinical notes supporting any of the above have been included in the submitted information.**

☐ Documentation included of genetic counseling that includes a pedigree, appropriate risk assessment, informed consent, discussion of the test's limitations and the psycho-social implications of the results from one of the following providers who is not affiliated with the genetic testing lab:
- Board-eligible or board certified genetics counselor
- Medical geneticist
- Other provider with expertise in genetics (e.g. oncologist, surgeon, gastroenterologist)

Additional Information that may support medical necessity:

_____

_____

_____

Attestation: I certify that the Aspirus Health Plan member noted above has given informed consent for the requested testing and that the results of this testing will be used by me to directly impact the management or treatment to be given to the member with a resulting improvement in health outcomes.

Signature of Treating Physician _____ Date _____