

Applies to:

Aetna plans

Innovation Health® plans

**Health benefits and health insurance plans offered and/or underwritten
by the following:**

Allina Health and Aetna Health Insurance Company (Allina Health | Aetna)

**Banner Health and Aetna Health Insurance Company and/or Banner Health and
Aetna Health Plan Inc. (Banner | Aetna)**

Sutter Health and Aetna Administrative Services LLC (Sutter Health | Aetna)

**Texas Health + Aetna Health Plan Inc. and Texas Health + Aetna Health Insurance
Company (Texas Health Aetna)**



BRCA Precertification Information Request Form

About this form

All BRCA tests require precertification. To initiate a request, please submit your request electronically or you can call our Precertification Department. **Failure to complete this form and submit all medical records we are requesting may result in the delay of review or denial of coverage.**

This form replaces all other BRCA precertification information request documents and forms.

How to fill out this form

As the patient's attending physician, you must complete **all** sections of this form. You can use this form with all Aetna health plans, including Aetna's Medicare Advantage plans. You can also use this form with health plans for which Aetna provides certain management services.

When you're done

We prefer you submit precertification requests electronically. Use our provider portal on Availity® to also upload clinical documentation, check statuses, and make changes to existing requests. Register today at availity.com/aetnaproviders or learn more about Availity at www.availity.com/aetnatraining.

- Precertification – Commercial and Medicare using FaxHub: **1-833-596-0339**.
The fax number above (FaxHub) is for clinical information only. Please send specific information that supports your medical necessity review. Please continue to send all other information (claims, etc.) to appropriate fax numbers: **833-596-0339**
- Mail your information to: **PO Box 14079**
Lexington, KY 40512-4079

Or you can submit the completed form and the specimen sample to one of our network BRCA testing laboratories listed below. Then they'll submit the form to us.

Quest Diagnostics, Inc.	Fax the precertification form to 1-855-422-5181 . Call BRCAvantage Concierge Services at 1-866-436-3463 or visit www.questvantage.com for more information
LabCorp	Fax the precertification form to 1-855-711-5699 . For questions, call 1-855-488-8750 or send email to BRCApriorauth@labcorp.com
Ambry Genetics	Fax the precertification form to 1-949-900-5501 . Order collection and transportation kits from by calling 1-866-262-7943 or online at www.ambrygen.com
Baylor Miraca Genetics Laboratories, LLC	Fax the precertification form to 1-713-798-2728 . Order collection and transportation kits by calling 1-800-411-GENE or 1-713-798-6555 or email geneticetest@bmgl.com
GeneDx, Genpath, BioReference	Fax the precertification form to 1-201-421-2010 . If you have any questions call 1-888-729-1206 or visit www.genedx.com
Invitae	Fax the precertification form to 1-415-276-4164 . If you have any questions, call 1-800-436-3037 or email clientservices@invitae.com or visit www.invitae.com/en/request-a-kit/
Medical Diagnostic Lab, LLC	Fax the precertification form to 1-609-570-1062 . If you have questions, call 1-877-269-0090 or visit www.mdlab.com
Myriad Genetics Laboratories, Inc.	Fax the precertification form to 1-801-584-3615 . If you have questions, call 1-800-469-7423
Progenity	Progenity – Submit the completed BRCA precertification form with a Riscover patient specimen. For questions or to receive specimen kits, call 855-293-2639.

What happens next?

Once we receive the requested documentation, we'll perform a clinical review. Then we'll make a coverage determination and let you know our decision.

How we make coverage determinations

For our Medicare Advantage members, we use CMS benefit policies, including national coverage determinations (NCD) and local coverage determinations (LCD) when available, to make our coverage determinations. If there isn't an available NCD or LCD to review, then we'll use the Clinical Policy Bulletin referenced below to make the determination.

For all other members, we encourage you to review **Clinical Policy Bulletin #227: BRCA Testing, Prophylactic Mastectomy, and Prophylactic Oophorectomy** before you complete this form.

You can find the Clinical Policy Bulletins and Precertification Lists by visiting the website on the back of the member's ID card.

Questions?

If you have any questions about how to fill out the form or our precertification process, call us at:

- HMO plans: **1-800-624-0756**
- Traditional plans: **1-888-632-3862**
- Medicare plans: **1-800-624-0756**

BRCA
Precertification Information Request Form

Failure to complete this form in its entirety may result in the delay of review.

Fax to: BRCA Precertification Department	Fax number: 1-833-596-0339
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Section 1: Member Demographics
If submitting request electronically, complete member name and ID only

Member name:	Member ID:
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Member address:

Member phone #:	Member date of birth: / /
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Biological Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Ashkenazi Jewish Ancestry: <input type="checkbox"/> Yes <input type="checkbox"/> No Other ancestry to be considered:
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Section 2: Provider Information

Name:	NPI number:
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Phone number:	Fax number: 1- - -
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Is provider participating? Yes No

Contact Name:	Contact Phone Number:
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Section 3: Genetic Counselor Information

If member does not have genetic counselor, enter NA here:

Name:	NPI:	TIN:
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Phone number: - -	Fax number: 1- - -
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Address:

BRCA
Precertification Information Request Form

Member Name:			
Member ID:		Reference Number:	
Section 4: Laboratory information Do not complete this section if submitting electronically			
Name:		Phone number:	
Is laboratory participating? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of specimen collection: / /	
ICD-10 code(s):			
Section 5: Test Requested			
<input type="checkbox"/> Germline <input type="checkbox"/> Somatic			
<input type="checkbox"/> BRCA 1/2 full gene sequence analysis WITH full large rearrangement (BART) analysis for hereditary cancer risk (Medicare members only) (CPT 81162)			
<input type="checkbox"/> BRCA1/2 full gene sequence analysis (CPT 81163)			
<input type="checkbox"/> BRCA 1/2 full large rearrangement (BART) analysis (Medicare members only) (CPT 81164)			
<input type="checkbox"/> BRCA1/2 three gene mutation (187delAG, 5385insC, 6174delT) analysis, Ashkenazi Jewish Ancestry (CPT 81212)			
<input type="checkbox"/> BRCA1/2 three gene mutation (187delAG, 5385insC, 6174delT) analysis, Ashkenazi Jewish Ancestry WITH reflex to full gene sequencing (CPT 81212 or CPT 81163)			
<input type="checkbox"/> BRCA 1 known deleterious familial variant (CPT 81215)		Mutation:	Family Member:
<input type="checkbox"/> BRCA 2 known deleterious familial variant (CPT 81217)		Mutation:	Family Member:
<input type="checkbox"/> BRCA1/2 testing for PARP- inhibitor treatment (CPT 81162 or 81163)		PARP inhibitor name:	
Names of previously failed therapies:	1.		
	2.		
	3.		
Section 6: Tested Member's cancer history			
<input type="checkbox"/> No history of Breast, Ovarian, Pancreatic or Prostate Cancer			
<input type="checkbox"/> Breast Cancer		<input type="checkbox"/> Unilateral	<input type="checkbox"/> Bilateral
Age at diagnosis:		<input type="checkbox"/> Triple Negative	<input type="checkbox"/> Metastatic
<input type="checkbox"/> Breast Cancer (recurrent, new primary)		<input type="checkbox"/> Unilateral	<input type="checkbox"/> Bilateral
Age at diagnosis:		<input type="checkbox"/> Triple Negative	<input type="checkbox"/> Metastatic
<input type="checkbox"/> Ovarian Cancer		<input type="checkbox"/> Metastatic	
<input type="checkbox"/> Pancreatic Cancer		<input type="checkbox"/> Metastatic	
<input type="checkbox"/> Prostate Cancer		<input type="checkbox"/> Metastatic	<input type="checkbox"/> Gleason Score Value:

BRCA
Precertification Information Request Form

Member Name:		
Member ID:		Reference Number:
Section 7: Member Testing History		
<input type="checkbox"/> No previous BRCA Genetic Testing	<input type="checkbox"/> Negative Ashkenazi Jewish Panel Testing	
<input type="checkbox"/> Negative BRCA 1/2 Gene Sequencing Testing	<input type="checkbox"/> Negative BRCA 1 / 2 Gene Sequencing Testing AND Large Rearrangement Testing	
Other: (Please Specify):		
Previous Testing Lab(s):		Date(s) of Test:
Results:		
Section 8: Family Medical\Cancer History		
<input type="checkbox"/> No Family History of breast, ovarian, pancreatic, or prostate cancer.		
Family member #1		
Relationship to member:	Biological gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	Is family member: <input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
<input type="checkbox"/> Breast Cancer; age at diagnosis: <input type="checkbox"/> Bilateral	<input type="checkbox"/> Ovarian; age at diagnosis <input type="checkbox"/> Pancreatic; Age at diagnosis:	<input type="checkbox"/> Prostate; age at diagnosis <input type="checkbox"/> Metastatic Gleason score:
Other cancer diagnoses or medical information:		
Family member #2		
Relationship to member:	Biological gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	Is family member: <input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
<input type="checkbox"/> Breast Cancer; age at diagnosis: <input type="checkbox"/> Bilateral	<input type="checkbox"/> Ovarian; age at diagnosis <input type="checkbox"/> Pancreatic; age at diagnosis:	<input type="checkbox"/> Prostate; age at diagnosis <input type="checkbox"/> Metastatic Gleason score:
Other cancer diagnoses or medical information:		
Family member #3		
Relationship to member:	Biological gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	Is family member: <input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
<input type="checkbox"/> Breast Cancer; age at diagnosis: <input type="checkbox"/> Bilateral	<input type="checkbox"/> Ovarian; age at diagnosis <input type="checkbox"/> Pancreatic; Age at diagnosis:	<input type="checkbox"/> Prostate; age at diagnosis <input type="checkbox"/> Metastatic Gleason score:
Other cancer diagnoses or medical information:		

Continued

BRCA
Precertification Information Request Form

Member Name:		
Member ID:		Reference Number:
Section 8, continued: Family Medical\Cancer History		
Family member #4		
Relationship to member:	Biological gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	Is family member: <input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
<input type="checkbox"/> Breast Cancer; age at diagnosis: <input type="checkbox"/> Bilateral	<input type="checkbox"/> Ovarian; age at diagnosis: <input type="checkbox"/> Pancreatic; Age at diagnosis:	<input type="checkbox"/> Prostate; age at diagnosis <input type="checkbox"/> Metastatic Gleason score:
Other cancer diagnoses or medical information:		
Additional Family Medical\Cancer History:		
Section 9: Intended medical management (if member tests positive)		
<input type="checkbox"/> Prophylactic oophorectomy <input type="checkbox"/> Bilateral	<input type="checkbox"/> Tamoxifen chemoprevention	<input type="checkbox"/> Other, please specify:
<input type="checkbox"/> Prophylactic mastectomy <input type="checkbox"/> Bilateral	<input type="checkbox"/> Increased breast surveillance	
Section 10: Member education		
Consistent with the 1997 National Institutes of Health Consensus Statement on guidelines for care of patients with BRCA1 and BRCA2 mutations and American College of Medical Genetics guidelines, prior to testing and follow-up treatment, the patient must give informed consent in accordance with applicable law. Also consistent with such guidelines, such informed consent discussions should include at least the following:		
1. Clarification of the patient's increased risk status	5. Limited data regarding efficacy of methods for early detection and prevention	
2. Explanation of how genetics affects cancer susceptibility	6. Possible psychological and social impact of testing	
3. Potential benefits, risk, and limitations of testing	7. Counseling regarding therapeutic options, including limitations	
4. Possible outcomes of testing (e.g., positive, negative or uncertain test results)		
Section 11: Read this important information		
Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.		

BRCA
Precertification Information Request Form

Member Name:	
Member ID:	Reference Number:
Section 12: Sign the form	
By signing this form, I certify that the member listed above has given informed consent in accordance with the guidelines and risks above and that the BRCA analysis will be used to direct the medical management of this member.	
Form completed by (please print):	Title:
Physician Signature (required):	
Contact Person:	Phone Number: