

**Breast and Ovarian Cancer Susceptibility Gene Testing,  
Prophylactic Mastectomy, and Prophylactic Oophorectomy  
Precertification Information Request Form**

**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)**



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# Breast and Ovarian Cancer Susceptibility Gene Testing, Prophylactic Mastectomy, and Prophylactic Oophorectomy Precertification Information Request Form

## About this form

**All BRCA tests require precertification. Do not use this form to initiate a precertification request.** To initiate a request, please submit your request electronically or you can call our Precertification Department. Submit your medical records to support the request with your electronic submission.

We've made it easy for you to authorize services and submit any requested clinical information. Just use our provider portal on Availity®. Register today at [Availity.com/aetnaproviders](https://www.availity.com/aetnaproviders). Once your account is ready, you can start submitting authorization requests right away.

- For additional information on Availity, go to <https://www.aetna.com/health-care-professionals/resource-center/availity.html>

## Requesting authorizations on Availity is a simple two-step process

Here's how it works:

1. Submit your initial request on Availity with the Authorization (Precertification) Add transaction.
2. Then complete a short questionnaire, if asked, to give us more clinical information.
  - If you receive a pended response, then complete this form and attach it to the case electronically.

**This form will help you supply the right information with your precertification request. Typed responses are preferred. Failure to complete this form and submit all medical records we are requesting may result in the delay of review or denial of coverage.**

## 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.

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## When you're done

Once you've filled out the form, submit it and all requested medical documentation to our Precertification Department by:

- If your request was submitted via telephone, you can either:
  - Access our provider portal via Availity; enter the Reference number provided and attach this form and all requested medical documentation to the case or
  - Send your information by confidential fax to:
    - **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.
  - If you do not have fax or electronic means to submit clinical:
    - Mail your information to: **PO Box 14079**  
**Lexington, KY 40512-4079**  
(Please note mailing will add to the review response time)

Or you can submit the completed form and the specimen sample to one of our network Breast and Ovarian Cancer Susceptibility Gene Testing, Prophylactic Mastectomy, and Prophylactic Oophorectomy testing laboratories listed below. Then they'll submit the form to us.

Quest Diagnostics, Inc.	Fax the precertification form to <b>1-855-422-5181</b> . Call BRCAVantage Concierge Services at <b>1-866-436-3463</b> or visit <a href="http://www.questvantage.com">www.questvantage.com</a> for more information
Labcorp	Fax the precertification form to <b>1-855-711-5699</b> . For questions, call <b>1-855-488-8750</b> or send email to <a href="mailto:BRCApriorauth@labcorp.com">BRCApriorauth@labcorp.com</a>
Ambry Genetics	Fax the precertification form to <b>1-949-900-5501</b> . Order collection and transportation kits from by calling <b>1-866-262-7943</b> or online at <a href="http://www.ambrygen.com">www.ambrygen.com</a>
Baylor Miraca Genetics Laboratories, LLC	Fax the precertification form to <b>1-713-798-2728</b> . Order collection and transportation kits by calling <b>1-800-411-GENE</b> or <b>1-713-798-6555</b> or email <a href="mailto:geneticetest@bmgll.com">geneticetest@bmgll.com</a>
Genpath and BioReference	Fax the precertification form to 201-839-9048. Order collection and transportation kits by calling 1-800-436-3037 or online at <a href="http://www.GenPathDiagnostics.com/hcp/oncology/hereditary-cancer-testing/">www.GenPathDiagnostics.com/hcp/oncology/hereditary-cancer-testing/</a>
Invitae	Fax the precertification form to <b>1-415-276-4164</b> . If you have any questions, call <b>1-800-436-3037</b> or email <a href="mailto:clientservices@invitae.com">clientservices@invitae.com</a> or visit <a href="http://www.invitae.com/en/request-a-kit/">www.invitae.com/en/request-a-kit/</a>
Medical Diagnostic Lab, LLC	Fax the precertification form to <b>1-609-570-1062</b> . If you have questions, call <b>1-877-269-0090</b> or visit <a href="http://www.mdlab.com">www.mdlab.com</a>
Myriad Genetics Laboratories, Inc.	Fax the precertification form to <b>1-801-584-3615</b> . If you have questions, call <b>1-800-469-7423</b>

## 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: Breast and Ovarian Cancer Susceptibility Gene 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**

## Breast and Ovarian Cancer Susceptibility Gene Testing, Prophylactic Mastectomy, and Prophylactic Oophorectomy Precertification Information Request Form

<b>Failure to complete this form in its entirety may result in the delay of review.</b>		
<b>Fax to:</b> BRCA Precertification Department	<b>Fax number:</b> 1-833-596-0339	
<b>Section 1: Member Demographics</b>		
<b>If submitting request electronically, complete member name and ID only</b>		
<b>Member name:</b>	<b>Member ID:</b>	
<b>Member address:</b>		
<b>Member phone #:</b>	<b>Member date of birth:</b> /     /	
<b>Biological Gender:</b> <input type="checkbox"/> M <input type="checkbox"/> F	<b>Ashkenazi Jewish Ancestry:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Other ancestry to be considered:	
<b>Section 2: Provider Information</b>		
<b>Provider name:</b>	<b>NPI number:</b>	
<b>Provider phone number:</b>	<b>Provider fax number:</b> 1-     -     -	
<b>Provider address:</b>		
<b>Is provider participating?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Contact Name:</b>	<b>Contact Phone Number:</b>	
<b>Section 3: Genetic Counselor Information</b>		
<b>If member does not have genetic counselor, enter NA here:</b>		
<b>Name:</b>	<b>NPI:</b>	<b>TIN:</b>
<b>Phone number:</b> -     -		

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<b>Member Name:</b>			
<b>Member ID:</b>		<b>Reference Number:</b>	
<b>Section 4: Laboratory information</b> Do not complete this section if submitting electronically			
<b>Name:</b>		<b>Phone number:</b>	
<b>Laboratory address:</b>			
Is laboratory participating? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of specimen collection:     /     /	
<b>ICD-10 code(s):</b>			
<b>Section 5: Test Requested</b> Refer to CPB 227 for Coverage Criteria			
<input type="checkbox"/> Germline <input type="checkbox"/> Somatic			
<input type="checkbox"/> <b>BRCA Hereditary breast cancer-related disorders genomic sequence analysis panel with at least 10 genes, always including BRCA1, BRCA2, CDH1, MLH1, MSH2, MSH6, PALB2, PTEN, STK11, and TP53 (CPT 81432)</b>			
<input type="checkbox"/> <b>BRCA Hereditary breast cancer-related disorders duplication/deletion analysis panel (CPT 81433)</b>			
<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)	PARP inhibitor name:		
<input type="checkbox"/> Other:			
Names of previously failed therapies:	1.		
	2.		
	3.		
<b>Section 6: Tested Member's cancer history</b>			
<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	<input type="checkbox"/> HER2 Negative
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	<input type="checkbox"/> HER2 Negative
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:	

## Breast and Ovarian Cancer Susceptibility Gene Testing, Prophylactic Mastectomy, and Prophylactic Oophorectomy Precertification Information Request Form

<b>Member Name:</b>		
<b>Member ID:</b>		<b>Reference Number:</b>
<b>Section 7: Member Testing History</b>		
<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:		
<b>Section 8: Family Medical\Cancer History</b>		
<input type="checkbox"/> No Family History of breast, ovarian, pancreatic, or prostate cancer.		
<b>Family member #1</b>		
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:		
<b>Family member #2</b>		
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:		
<b>Family member #3</b>		
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*

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<b>Member Name:</b>		
<b>Member ID:</b>		<b>Reference Number:</b>
<b>Section 8, continued: Family Medical\Cancer History</b>		
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:		
<b>Section 9: Intended medical management (if member tests positive)</b>		
<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	
<b>Section 10: Member education</b>		
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 2. Explanation of how genetics affects cancer susceptibility 3. Potential benefits, risk, and limitations of testing 4. Possible outcomes of testing (e.g., positive, negative or uncertain test results)	5. Limited data regarding efficacy of methods for early detection and prevention 6. Possible psychological and social impact of testing 7. Counseling regarding therapeutic options, including limitations	
<b>Section 11: Read this important information</b>		
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.		

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<b>Member Name:</b>	
<b>Member ID:</b>	<b>Reference Number:</b>
<b>Section 12: Sign the form</b>	
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.	
<b>Form completed by (please print):</b>	<b>Title:</b>
<b>Physician Signature (required):</b>	
<b>Contact Person:</b>	<b>Phone Number:</b>