Hereditary Breast and Ovarian Cancer (HBOC) Genetic Testing Prior Authorization Form Instructions

Instructions: To request prior authorization for BRCA 1 and BRCA 2 genes and BRACAnalysis Rearrangement Test (Reflex to BART) testing for breast and ovarian cancer, complete the Hereditary Breast and Ovarian Cancer Genetic Testing Prior Authorization Form. This form must be completed and signed as outlined in the instructions below. The completed form with the original dated signature must be retained by the requesting physician in the client's medical record. The form is subject to retrospective review.

The following forms, documents, and information must be submitted to request prior authorization:

- The completed and signed Hereditary Breast and Ovarian Cancer Genetic Testing Prior Authorization Form
- All medical necessity documentation , including documentation of the efforts made to obtain the test results of previous comprehensive sequencing when appropriate
- Attestation for comprehensive testing. The attestation must indicate that familial BRCA testing results could not be obtained (as necessary).

The completed prior authorization form and all necessary attachments must be submitted to the TMHP Special Medical Prior Authorization Department by fax to 1-512-514-4213 or by mail at:

Texas Medicaid & Healthcare Partnership
Attention: Special Medical Prior Authorization Department
12365-A Riata Trace Pkwy., Ste. 100
Austin, TX 78727

Providers can refer to the *Texas Medicaid Provider Procedures Manual* and the Texas Medicaid fee schedules that are available on the TMHP website at www.tmhp.com for information about procedure codes and prior authorization requirements.

Fields marked with an asterisk below indicate an essential/critical field. If these fields are not completed, your prior authorization request will be returned.

Field	Description
Prior Authorization Request Submitter Certification Statement	
Read the certification Statement and select "We Agree."	
Section A: Client information	
Name*:	Enter the client's name as indicated on the client's Texas Medicaid eligibility card or form.
Medicaid number*:	Enter the client's Medicaid number as indicated on the client's Texas Medicaid eligibility card or form.
Date of birth*:	Enter the client's date of birth as indicated on the client's Texas Medicaid eligibility card or form.
Section B: Requested procedure or service information	
Check one: (Initial or Repeat request)	Indicate if this request is for initial BRCA1 and BRCA2 testing, or if the testing must be repeated because initial results are not available and large rearrangement testing is necessary. **Note:** *The physician must make every reasonable effort to obtain from the previous physician any available BRCA1 and BRCA2 test results for the client and must submit documentation of the efforts made to obtain the test results of previous comprehensive sequencing.*

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Field	Description
Expected dates of service: From and To*	Enter the expected date or dates of service for the requested procedure.
Procedure requested – CPT code*	Enter the appropriate and most specific procedure code for the service or services being requested.
Procedure code description	Enter a brief description of the requested service or services.
Comments:	Enter additional comments if applicable.
Section C: Medical necessity information	
Diagnosis codes:	Enter a valid and appropriate diagnosis code with a brief description.
Medical necessity:	Enter the information about relatives with ovarian or breast cancer. Add additional information as necessary that provides justification to support the medical necessity for the requested service or services. Add additional pages as necessary. **Client counseling documentation** – Documentation from client counseling can be included with the prior authorization request to support the medical necessity of genetic testing. Summary notes from a board certified genetic counselor or medical geneticist, (not affiliated with the testing lab) can indicate a recommendation for BRCA or BART genetic testing, per NCCN Guidelines. **Important:** *All requests for hereditary breast/ovarian cancer genetic testing must meet Nation Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology (NCCN Guidelines).*
Information about close blood relatives from the same side of the family who have been diagnosed with ovarian, breast, prostate (Gleason score of 7 or greater), or pancreatic cancer, or who have had positive BRCA1 or BRCA2 test results with no diagnosis of cancer:	For each relative who has been diagnosed with ovarian or breast cancer, enter the following information: a. Age at Diagnosis – Enter the age of each relative when they were diagnosed with ovarian or breast cancer. b. Gender – Enter the gender of each relative who has been diagnosed with ovarian or breast cancer. c. Cancer Diagnosis – Enter the relative's cancer diagnosis. d. Relationship to Client – Enter the relative's relationship to the client. e. Positive BRCA1 or BRCA2 Results – Check "Yes" if the relative had a positive BRCA1 or BRCA2 test result, or check "No" if the relative had a negative BRCA1 or BRCA2 test result or if no BRCA1 or BRCA2 testing was conducted. **Note:** *A close blood relative includes a 1st (parent, sibling, offspring), 2nd (aunt, uncle, grandparent, niece, nephew, grandchildren, half-sibling), or 3rd (first cousin, great-grandparent, great-aunt, great-uncle, great-grandchildren) degree male or female blood relative from the same side of the family.*
For full sequence or gene variants: Positive familial BRCA testing results could not obtained	Check "yes" or "no" to indicate whether or not the positive familial BRCA Testing results could be obtained from the client.
Ethnic decent of client if associated with deleterious mutations	Enter the ethnic decent of the client if the testing is associated with deleterious mutations (including, but not limited to: Ashkenazi Jewish, Icelandic Swedish, or Hungarian).
Requesting physician's name*:	Enter the physician's name.

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Field	Description
Address/City/ZIP:	Enter the physician's office address include city and ZIP + 4 code.
Telephone:	Enter the physician's office contact telephone number.
Fax:	Enter the physician's office Fax number.
Tax ID:	Enter the physician's Tax Identification Number (TIN).
NPI*:	Enter the physician's National Provider Identifier (NPI).
Taxonomy:	Enter the appropriate taxonomy code (if applicable).
Benefit Code:	Enter the physician's Benefit Code.
Physician's signature:	Sign the form. **Note:** *Signatures from nurse practitioners, physician assistants, and chiropractors will not be accepted. Signature stamps and date stamps are not acceptable.*
Date signed:	Enter the date the physician signed the form.
Section D: Requirements for Genetic Counseling and Client Consent for Testing	
Date the client received pre-testing genetic counseling:	Indicate the date the client received pre-testing genetic counseling.
Name of person who provided pre-testing counseling:	Indicate the name of the genetic counselor, or other qualified individual that provided the pre-testing genetic counseling to the client.
Qualifications of person providing pre-testing counseling:	Indicate the qualifications of the individual that provided the pre-testing genetic counseling to the client.
Counselor telephone:	Provide the telephone number of the genetic counselor, or other qualified individual that provided the pre-testing genetic counseling to the client.
Counselor fax:	Provide the fax number of the genetic counselor, or other qualified individual that provided the pre-testing genetic counseling to the client.
Date client consent was obtained for the genetic testing:	Indicate the date the client signed the written consent to receive genetic testing.
Section E: Rendering Laboratory Provider information	
Provider name*:	Enter the name of the laboratory facility where the genetic testing will be rendered.
Address/City/ZIP*:	Enter the address of the laboratory facility including the city and ZIP + 4 code.
Contact person:	Enter the name of the laboratory contact person at the facility.
Telephone:	Enter the telephone number of the laboratory contact person.
Fax:	Enter the laboratory facility fax number.
Tax ID*:	Enter the laboratory facility Tax Identification Number (TIN).
NPI*:	Enter the laboratory facility National Provider Identifier (NPI).
Taxonomy*:	Enter the appropriate taxonomy code (if applicable).
Benefit Code*:	Enter the laboratory benefit code.

Hereditary Breast and Ovarian Cancer (HBOC) Genetic Testing Prior Authorization Form: Client Informed Consent for Hereditary Cancer Genetic Testing

Submit your prior authorization using TMHP's PA on the Portal and receive request decisions more quickly than faxed requests. With PA on the Portal, documents will be immediately received by the PA Department, resulting in a quicker decision. Fax requests must be scanned and data entered before the PA Department receives them, which can take up to 24 hours. To access PA on the Portal, go to www.tmhp.com and select "Prior Authorization" from the Topics drop-down menu. Then click the PA on the Portal button and enter your TMHP Portal Account user name and password. To submit by fax, send to **512-514-4213**.

Note: *If any portion of this form is incomplete, it may result in your prior authorization request being pended for additional information.*

Prior Authorization Request Submitter Certification Statement

I certify and affirm that I am either the Provider, or have been specifically authorized by the Provider (hereinafter "Prior Authorization Request Submitter") to submit this prior authorization request.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that they are personally acquainted with the information supplied on the prior authorization form and any attachments or accompanying information and that it constitutes true, correct, complete and accurate information; does not contain any misrepresentations; and does not fail to include any information that might be deemed relevant or pertinent to the decision on which a prior authorization for payment would be made.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that the information supplied on the prior authorization form and any attachments or accompanying information was made by a person with knowledge of the act, event, condition, opinion, or diagnosis recorded; is kept in the ordinary course of business of the Provider; is the original or an exact duplicate of the original; and is maintained in the individual patient's medical record in accordance with the *Texas Medicaid Provider Procedures Manual* (TMPPM).

The Provider and Prior Authorization Request Submitter certify and affirm that they understand and agree that prior authorization is a condition of reimbursement and is not a guarantee of payment.

The Provider and Prior Authorization Request Submitter understand that payment of claims related to this prior authorization will be from Federal and State funds, and that any false claims, statements or documents, concealment of a material fact, or omitting relevant or pertinent information may constitute fraud and may be prosecuted under applicable federal and/or State laws. The Provider and Prior Authorization Request Submitter understand and agree that failure to provide true and accurate information, omit information, or provide notice of changes to the information previously provided may result in termination of the provider's Medicaid enrollment and/or personal exclusion from Texas Medicaid.

The Provider and Prior Authorization Request Submitter certify, affirm and agree that by checking "We Agree" that they have read and understand the Prior Authorization Agreement requirements as stated in the relevant *Texas Medicaid Provider Procedures Manual* and they agree and consent to the Certification above and to the Texas Medicaid & Healthcare Partnership (TMHP) Terms and Conditions.

☐ **We Agree**

Hereditary Breast and Ovarian Cancer (HBOC) Genetic Testing Prior Authorization Form: Client Informed Consent for Hereditary Cancer Genetic Testing

Note: *Fields marked with an asterisk below indicate an essential/critical field. If these fields are not completed, your prior authorization request will be returned.*

Section A: Client information

Name*:	
Medicaid number*:	Date of birth*:

Section B: Requested procedure or service information

Check one:

☐ This request is for initial BRCA1 and BRCA2 testing.

☐ This request is for repeat BRCA1 and BRCA2 comprehensive sequencing testing for the client because initial results are not available and large rearrangement testing is necessary. **Note:** The physician must make every reasonable effort to obtain from the previous physician any available BRCA1 and BRCA2 test results for the client and must submit documentation of the efforts made to obtain the test results of previous comprehensive sequencing.

Expected Dates of Service From*: To*:

Procedure code requested*	**Procedure code description**

Comments:

Section C: Medical necessity information (Additional pages or documents may be attached as necessary)

Diagnosis codes:

Medical necessity:

Information about close blood relatives from the same side of the family who have been diagnosed with ovarian, breast, prostate (Gleason score of 7 or greater), or pancreatic cancer, or who have had positive BRCA1 or BRCA2 test results with no diagnosis of cancer :

Relative	**a. Age**	**b. Gender**	**c. Cancer Diagnosis**	**d. Relationship to Client**	**e. Positive BRCA1 or BRCA2 Results**
Relative #1:					☐ Yes ☐ No
Relative #2:					☐ Yes ☐ No
Relative #3:					☐ Yes ☐ No
Relative #4:					☐ Yes ☐ No

* Essential/Critical field

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Section C: Medical necessity information (Additional pages or documents may be attached as necessary)

For full sequence or gene variants: Positive familial BRCA testing results could not be obtained			☐ Yes ☐ No
Ethnic decent of client if associated with deleterious mutations (including, but not limited to: Ashkenazi Jewish, Icelandic Swedish, or Hungarian):			
Requesting physician's name*:			
Street address:			
City:		State:	ZIP + 4:
Telephone:		Fax:	
Tax ID:	NPI*:	Benefit Code:	Taxonomy:
Physician's signature:			Date signed:

Section D: Requirements for genetic counseling and client consent

The client must receive pre-testing genetic counseling and provide consent in writing for genetic testing before the prior authorization request is submitted and the blood specimen is obtained.

Date the client received pre-testing genetic counseling:		
Name of person who provided pre-testing counseling:		
Qualifications of person providing pre-testing counseling:		
Counselor telephone number:	Counselor fax number:	
Date client consent was obtained for the genetic testing:		

Section E: Rendering laboratory provider information

Rendering provider name*:			
Street address*:			
City:		State:	ZIP + 4*:
Contact person:			
Telephone:	Fax:		
Tax ID*:	NPI*:	Benefit Code*:	Taxonomy*:

* Essential/Critical field