PRIOR AUTHORIZATION for BREAST CANCER PROGNOSIS TESTING

For authorization, please complete this form, include patient chart notes to document information and FAX to the PEHP Prior Authorization Department at (801) 366-7449 or mail to: 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization or benefit questions, please call PEHP Member and Provider Services at (801) 366-7555 or toll free at (800) 753-7490.

Section I: PATIENT INFORMATION

Date Requested:	Name (Last, First MI):	DOB:	Age:	PEHP ID #:

Section II: PROVIDER(S) INFORMATION

Ordering Provider:	*Ordering* Provider Specialty:	*Ordering* Provider Address:

Provider NPI #:	Provider TIN #:	Contact Person:	Phone:	Facsimile:	Email Address:
			( )	( )	

Rendering Laboratory Name: *	*Rendering* Provider Address:

Provider NPI #:	Provider TIN #:	Contact Person:	Phone:	Facsimile:	Email Address:
			( )	( )	

Section III: PRE-AUTHORIZATION REQUEST

A. Nature of Request: ***Please check.***

☐ Auth Extension ☐ Pre-Auth ☐ Retrospective Auth

B. Date Sample Collected:

C. Primary Diagnosis/ICD-10 Code:

D. Secondary Diagnosis/ICD-10 Code:

E. Patient's Personal History of Cancer:

Age at Diagnosis: _____ Type/Location of Cancer/Disease Name:_____

Age at Diagnosis: _____ Type/Location of Cancer/Disease Name:_____

F. Breast Cancer Prognosis Testing: **** Completion of this section is mandatory.***

1. **Size of Tumor:** ***Please check.***
   - **a.** ☐ < 0.5 cm **b.** ☐ > 0.5 cm
2. **Type of Breast Cancer:** ***Please check all that apply.***
   - **a.** ☐ Ductal Carcinoma **b.** ☐ Inflammatory **c.** ☐ In Situ (Non-Invasive) **d.** ☐ Invasive **e.** ☐ Lobular Carcinoma **f.** ☐ Paget's Disease
3. **Human Epidermal Growth Factor Receptor 2 (HER2) Results:** ***Please check.***
   - **a.** ☐ Negative **b.** ☐ Positive
4. **Hormone Receptor Results:** ***Please check.***
   - **a. Estrogen Receptor (ER) Results:** ☐ Negative ☐ Positive
   - **b. Progesterone Receptor (PR) Results:** ☐ Negative ☐ Positive
5. **Lymph Node Biopsy Testing Results:** ***Please check.***
   - **a. Was the lymph node biopsy testing negative (pN0)?** ☐ Yes ☐ No
     - **a. 1. If "*No*" was their axillary lymph node micrometastasis less than 2mm (pN1mi)?** ☐ Yes ☐ No
     - **a. 2. If "*No*" were there only 1 to 3 ipsilateral axillary lymph nodes involved?** ☐ Yes ☐ No
6. **Is adjuvant chemotherapy precluded due to any other factor (e.g., advanced age and/or significant comorbidities)?** ***Please check.*** ☐ Yes ☐ No
7. **Will the patient undergo adjuvant chemotherapy if test results show "High Risk Breast Cancer"?** ***Please check.*** ☐ Yes ☐ No

G. Testing Requested: ***Please list all requested services regardless of pre-authorization requirement. Unlisted codes cannot be pre-authorized.***

Name of Test/Panel Name: _____ **Genes to be Tested:** _____

CPT code (s)/Number of Units: _____ *ICD-10 Code(s):* _____

Name of Test/Panel Name: _____ **Genes to be Tested:** _____

CPT code (s)/Number of Units: _____ *ICD-10 Code(s):* _____

Additional Comments:

By submitting this form, I attest that the information provided is true and accurate to the best of my knowledge.

Please fax completed form and medical records to 801-366-7449.

***PEHP reserves the right to designate which laboratory will provide the services.**