PRIOR AUTHORIZATION for GENETIC TESTING – PROSTATE 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* Laboratory 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: ***Testing 1 x only***

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: _____

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

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

1. **Pre-Prostate Biopsy Prostate Specific Antigen (PSA) Score:** _____
2. **Prostate Biopsy Date:** _____
3. **Grade Group:**
   - **a.** ☐ 1 (Gleason Score 6) **b.** ☐ 2 (Gleason Score 3+4=7) **c.** ☐ 3 (Gleason Score 4+3=7) **d.** ☐ 4 (Gleason Score 8) **e.** ☐ 5 (Gleason Score 9 or 10)
4. **National Comprehensive Cancer Network (NCCN) Risk Group:**
   - **a.** ☐ Very Low **b.** ☐ Low **c.** ☐ Favorable Intermediate **d.** ☐ Unfavorable Intermediate **e.** ☐ High **f.** ☐ Very High
5. **Patient's Life Expectancy:** **a.** ☐ Less than 10 years **b.** ☐ Greater than 10 years
6. **Is testing being used to determine if active surveillance or definitive therapy is recommended?** ☐ Yes ☐ No
7. **Is testing being used to determine if androgen-deprivation therapy will be added to radiation therapy?** ☐ Yes ☐ No
8. **Did the patient undergo a prostatectomy?** ☐ Yes ☐ No
   - **a. If "*Yes*", does the patient have a persistent or rising PSA (biochemical recurrence of 0.2 ng/d)?** ☐ Yes ☐ No
     - **I. If "*Yes*", is testing being used to determine adjuvant versus salvage radiation therapy?** ☐ Yes ☐ No
     - **II. If "*Yes*", is testing being used to determine whether to initiate systemic therapies?** ☐ Yes ☐ No

G. Testing Requested: ***Please list all requested services/CPT codes 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.**