

PRIOR AUTHORIZATION for GENETIC 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 #:
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Section II: PROVIDER(S) INFORMATION

Ordering Provider:		Ordering Provider Specialty:		Ordering Provider Address:	
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Provider NPI #:	Provider TIN #:	Contact Person:	Phone: ()	Facsimile: ()	Email Address:
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Rendering Laboratory Name: *		Rendering Laboratory Address:			
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Provider NPI #:	Provider TIN #:	Contact Person:	Phone: ()	Facsimile: ()	Email Address:
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Section III: PRE-AUTHORIZATION REQUEST

A. Nature of Request: Please check. <input type="checkbox"/> Auth Extension <input type="checkbox"/> Pre-Auth <input type="checkbox"/> Retrospective Auth		B. Date Sample Collected: Testing 1 x only		C. Requested Date(s) of Service: Testing more than 1 x From: _____ To: _____	
D. Primary Diagnosis/ICD-10 Code:		E. Secondary Diagnosis/ICD-10 Code:		F. Has the patient had a consultation with either a Geneticist or a Genetic Counselor? Please check. <input type="checkbox"/> Yes <input type="checkbox"/> No	

G. Type of Genetic / Molecular Diagnostic Testing: Please check. 1. <input type="checkbox"/> Germline/Inherited DNA Testing 2. <input type="checkbox"/> Somatic/Tumor Testing 3. <input type="checkbox"/> Pharmacogenomic Testing * Complete Section K. also. 4. <input type="checkbox"/> Other (please specify): _____				H. Specimen Source: Please check. 1. <input type="checkbox"/> Amniotic Fluid 5. <input type="checkbox"/> Chorionic Villi (CVS) 2. <input type="checkbox"/> Blood 6. <input type="checkbox"/> Lymphatic Tissue 3. <input type="checkbox"/> Bone Marrow or Core 7. <input type="checkbox"/> Solid Tumor 4. <input type="checkbox"/> Buccal Mucosa 8. <input type="checkbox"/> Tissue/Skin	
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I. Does the patient have a personal history of cancer or other diseases related to testing being requested? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please add information below.					
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Age at Diagnosis: _____ Type/Location of Cancer/Disease Name: _____

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

J. Does the patient have a family history related to testing being ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please add info below.					
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Relationship: _____ Maternal Paternal Diagnosis: _____ Age at Diagnosis: _____

Relationship: _____ Maternal Paternal Diagnosis: _____ Age at Diagnosis: _____

Relationship: _____ Maternal Paternal Diagnosis: _____ Age at Diagnosis: _____

K. Pharmacogenomic Testing: * Completion of this section is mandatory if service being requested. <input type="checkbox"/> N/A					
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Drug Name: _____ Indication for Drug (e.g., cancer): _____

Drug Name: _____ Indication for Drug (e.g., cancer): _____

L. Testing Requested: Please list all requested services/CPT codes regardless of pre-authorization requirement. Unlisted codes cannot be pre-authorized.					
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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): _____

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.**