PRIOR AUTHORIZATION for GENETIC and SPECIALTY LABORATORY 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 Customer Service at (801) 366-7555 or toll free at (800) 753-7490.

Section I: PATIENT INFORMATION

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

Section II: PROVIDER INFORMATION

Date Requested:	Ordering Physician:	Physician NPI #:
Physician Address:	Phone: ( )	Facsimile: ( )
Laboratory Name: *	Laboratory NPI #:	Laboratory Tax ID #:
Laboratory Contact Person:	Phone: ( )	Facsimile: ( )

Section III: PRE-AUTHORIZATION REQUEST

Nature of Request: *Please check.* ☐ Auth Extension ☐ Pre-Auth ☐ Retro Auth ☐ Urgent	**Date Sample Collected:**	**Specimen Source:** *Please check.* ☐ Amniotic Fluid ☐ Blood ☐ Saliva ☐ Tissue

Primary Diagnosis/ICD-10 Code:	**Secondary Diagnosis/ICD-10 Code:**

A. Indication (s) for Genetic Testing: *Please check.*

1. ☐ Carrier 2. ☐ Diagnostic 3. ☐ Newborn Screening 4. ☐ Pharmacogenomic 5. ☐ Preconception "(Family Planning") 6. ☐ Predictive – Presymptomatic
7. ☐ Prenatal (*Will the patient be 35 years old at time of delivery?* ☐ Yes ☐ No) 8. ☐ Other (*please specify*) _____

B. Pharmacogenomic Testing:

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

C. Test (s) Requested: **Name of Panel (*if applicable*):** _____

Name of Test: _____ CPT code (s): _____ ICD-10 Code: _____
Name of Test: _____ CPT code (s): _____ ICD-10 Code: _____
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Name of Test: _____ CPT code (s): _____ ICD-10 Code: _____

D. Does the patient have a personal history of cancer? ☐ Yes ☐ No

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

E. Patient's personal clinical history related to testing being requested:

F. Family history related to testing being ordered if applicable:

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

G. How testing will be used in relation to treatment: ***(Completion of this field is required.)***

Additional Comments:

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

Ordering Provider Signature: _____ **Date:** _____

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