**VERMONT GENETIC TESTING PRIOR AUTHORIZATION FORM**

**Please verify if the genetic testing code(s) require prior authorization prior to submitting the request. Information can be found on the Vermont Medicaid Fee Schedule:** [**http://www.vtmedicaid.com/#/feeSchedule**](http://www.vtmedicaid.com/#/feeSchedule)

Date of Request: \_\_\_/\_\_\_\_/\_\_\_\_\_ Date, if procedure has been scheduled: \_\_\_/\_\_\_\_/\_\_\_\_\_

**Beneficiary Information:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicaid ID #: \_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_\_/\_\_\_\_\_ Gender: M F

**Provider Information:**

Requesting Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

VT. Medicaid Provider #: \_\_\_\_\_\_\_\_\_\_\_\_ Requesting Provider NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Requesting Provider Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Supplying Provider Information:**

Supplying Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

VT. Medicaid Provider #: \_\_\_\_\_\_\_\_\_\_\_\_ Supplying Provider NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supplying Provider Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Genetic Test Information:**

Requested Genetic Test:

BRCA 1 and 2, HBOC Breast mRNA Cardiology Gene Expression (AlloMap)

Colon Cancer Lynch Syndrome Cystic Fibrosis Hereditary Hemochromatosis Gene Analysis

Huntington’s Disease Janus Kinase 2(JAK2) Fragile X Syndrome

Familial Adenomatous Polyposis/ Assoc. Polyposis Conditions Whole Genome Microarray

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CPT Code: \_\_\_\_\_\_\_\_\_\_\_\_ Procedure Description:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD-10 Diagnosis Code:\_\_\_\_\_\_\_\_\_\_\_\_ Diagnosis Description:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CPT Code: \_\_\_\_\_\_\_\_\_\_\_\_ Procedure Description:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD-10 Diagnosis Code:\_\_\_\_\_\_\_\_\_\_\_\_ Diagnosis Description:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CPT Code: \_\_\_\_\_\_\_\_\_\_\_\_ Procedure Description:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD-10 Diagnosis Code:\_\_\_\_\_\_\_\_\_\_\_\_ Diagnosis Description:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Information – All Procedures:**

**Provide convincing information to justify each test requested on page 1.**

1. Why is the test appropriate for the patient?

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1. Does the beneficiary exhibit clinical features of the mutation in question? If not, has a genetic variant been identified in a family member?

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1. Has the patient given informed consent to the genetic test? Yes No
2. Has genetic counseling occurred? Yes No
3. What is the validity of testing and is the testing scientifically sound?

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1. Is the patient willing to undergo the increased interventions that may potentially be required because of testing? Yes No
2. How will the results specifically impact or alter medical management of the patient?

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1. What is the cost of the test?

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1. Is multigene panel testing more cost efficient than the combined reimbursement for single codes?

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**Signature of Requesting Provider:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_/\_\_\_\_/\_\_\_\_\_