**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?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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:** \_\_\_/\_\_\_\_/\_\_\_\_\_