Medical Necessity Form: Genetic Testing for Inherited BRCA1 or BRCA2

BlueCross BlueShield of Delaware

BCBSD requires that prior authorization for BRCA1 and BRCA2 genetic testing be obtained prior to ordering the test. In order for BCBSD to gather relevant medical information for review, providers must complete and sign the form below. Completed forms should be faxed to BCBSD's Medical Management Department at ***302.421.8864*** or ***800.670.4862****.*

Patient Information		
Patient Name		
Patient's Date of Birth	**BCBSD Member ID Number**	**Proposed Date of Service**

Physician and Genetic Counselor Information		
Ordering Physician Name	**Phone Number**	**Fax Number**
Rendering Physician Name	**Phone Number**	**Fax Number**
Procedure Code	**Diagnosis Code(s)**	
Genetic Counselor Name	**Phone Number**	**Date of Visit**
Outcome: Genetic Testing Recommended Y N	Patient Requested Test Y N	

Please check Y to those that apply to the patient (personal history) and/or the patient's family (family history, on either the mother or father's side). If Y is checked, please also list the relationship to the patient of the individual diagnosed (e.g., self, maternal aunt, sister, paternal cousin) and her/his age at diagnosis.

Hereditary Breast and Ovarian Cancer Syndrome			
Y N	Biologically related individual from a family with a known BRCA1 or BRCA2 mutation	**Relationship**	**Age at Diagnosis**
Y N	Personal history of breast cancer at or before age 45	**Relationship** Self	**Age at Diagnosis**
Y N	Personal history of breast cancer at or before age 50	**Relationship** Self	**Age at Diagnosis**
Y N	Personal history of breast cancer at any age	**Relationship** Self	**Age at Diagnosis**
Y N	Personal history of breast cancer and an individual of ethnicity associated with higher mutation frequency (e.g., Ashkenazi Jewish, Icelandic, Swedish, Hungarian or other)	**Relationship** Self	**Age at Diagnosis**
Y N	Personal history of epithelial ovarian, fallopian tube, or primary peritoneal cancer at any age	**Relationship** Self	**Age at Diagnosis**
Y N	Personal history of male breast cancer	**Relationship** Self	**Age at Diagnosis**
Y N	Family history only —meeting any of the above criteria	**Relationship**	**Age at Diagnosis**
Y N	Personal history of triple negative breast cancer under age 60	**Relationship** Self	**Age at Diagnosis**
Y N	Individual with at least a 10% risk of carrying a BRCA mutation based on validated quantitative risk assessment tools (BRCAPRO, Yale, Univ of PA, BOADICEA and Tyrer-Cuzick)	Please send a pedigree and a copy of the models >10%	

Please provide any additional information regarding the reason for testing:

I confirm that information given on this form is accurate as of this date.

Signature of Physician or Authorized Representative Date