Medical Necessity Form: Genetic Testing for Inherited Susceptibility to Colon Cancer

BlueCross BlueShield of Delaware

*BCBSD requires that prior authorization for Inherited Susceptibility to Colon Cancer 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 Colon Cancer

Y **N**	Lynch Syndrome	**Relationship**	**Age at Diagnosis**
Y **N**	Diagnosed with colorectal, endometrial or ovarian cancer before the age of 50 years	**Relationship**	**Age at Diagnosis**
Y **N**	History of synchronous or metachronous colorectal or other HNPCC-related tumors (which include endometrial, stomach, ovarian, pancreatic, bladder, ureter, renal pelvis, biliary tract, brain (glioblastoma), sebaceous gland carcinoma and/or adenoma, keratoacanthoma, and carcinoma of the small bowel), regardless of age	**Relationship**	**Age at Diagnosis**
Y **N**	Colorectal or endometrial cancer with a high microsatellite-instability morphology and/or loss of one or more of the MMR genes on IHC (DNA sequencing for the gene(s) related to loss of protein(s) expression by IHC)	**Relationship**	**Age at Diagnosis**
Y **N**	History of colorectal cancer or a HNPCC associated cancer with one or more first-degree relatives with colorectal cancer or other HNPCC-related tumors. One of the cancers must have been diagnosed before the age of 50 years	**Relationship**	**Age at Diagnosis**
Y **N**	Colorectal or a HPNCC associated cancer with two or more first- or second-degree relatives with colorectal cancer or other HNPCC-related tumors, regardless of age	**Relationship**	**Age at Diagnosis**
Y **N**	Familial Adenomous Polyposis (FAP)/ MUTYH-associated polyposis (MAP)	**Relationship**	**Age at Diagnosis**
Y **N**	10 or more colonic polyps found upon testing	**Relationship**	**Age at Diagnosis**
Y **N**	FAP diagnosed in a first-degree relative (siblings, parents, offspring)	**Relationship**	**Age at Diagnosis**

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