REVIEW REQUEST FOR

Genetic Testing for Breast and/or Ovarian Cancer Syndrome

Anthem UM Services, Inc.

Provider Data Collection Tool Based on Medical Policy GENE.00029

Policy Last Review Date: 11/08/2018	Publish Date: 12/27/2018	Provider Tool Effective Date: 08/29/2018

Individual's Name:	Date of Birth:
Insurance Identification Number:	Individual's Phone Number:
Ordering Provider Name & Specialty:	Provider ID Number:
Office Address:	
Office Phone Number:	Office Fax Number:
Rendering Provider Name & Specialty:	Provider ID Number:
Office Address:	
Office Phone Number:	Office Fax Number:
Facility Name:	Facility ID Number:
Facility Address:	

Date/Date Range of Service:	Place of Service: ☐ Home ☐ Inpatient
Service Requested (CPT if known):	☐ Outpatient ☐ Other: _____
Diagnosis Code(s) (if known):	

This medical policy based data collection tool is for a medical necessity review request for genetic testing for individuals who are at higher than average risk for the development of breast and/or ovarian cancer.

☐ Request is for genetic testing for BRCA (BRCA1 and/or BRCA2) mutations and/or large genomic rearrangements (BART)
(If checked, mark the following that apply to the individual)

- ☐ Individual will undergo genetic counseling with the following components
  (Mark all of the following that apply)
  - ☐ Interpretation of family and medical histories to assess the probability of disease occurrence or recurrence
  - ☐ Education about inheritance, genetic testing, disease management, prevention, and resources
  - ☐ Counseling to promote informed choices and adaptation to the risk or presence of a genetic condition
  - ☐ Counseling for the psychological aspects of genetic testing

- ☐ Individual is from a family with a known deleterious BRCA1/BRCA 2 mutation

- ☐ Individual has a **personal history of cancer**
  (If checked, mark the following that apply to the individual)
  - ☐ Individual was diagnosed with breast cancer at less than or equal to 45 years of age
  - ☐ Individual has a history of breast cancer diagnosed at any age and at least one first-, second-, or third-degree relative with breast cancer diagnosed at less than or equal to 50 years of age
  - ☐ Individual has multiple primary breast cancers (bilateral [contralateral] disease or two or more separate ipsilateral primary tumors either synchronously or asynchronously)
  - ☐ Individual is a **male** with breast cancer
  - ☐ Individual has triple negative breast cancer diagnosed at less than or equal to 60 years of age
  - ☐ Individual has a history of breast cancer and a first-, second-, or third-degree **male** relative with breast cancer
  - ☐ Individual has a history of breast cancer and 2 or more first-, second-, or third-degree relatives on the same side of the family with pancreatic cancer

- ☐ Individual has a history of ovarian cancer
- ☐ Individual has a history of fallopian tube cancer
- ☐ Individual has a history of primary peritoneal cancer
- ☐ Individual has a history of pancreatic cancer and a first-, second-, or third-degree relative with breast cancer (diagnosed at less than or equal to 50 years of age) and/or ovarian, fallopian tube, primary peritoneal, or pancreatic cancer at any age
- ☐ Individual is of Ashkenazi Jewish descent and has a history of pancreatic cancer
- ☐ Individual has a history of breast cancer and at least 2 or more first-, second-, or third-degree relatives on the same side of the family with breast cancer
- ☐ Individual has a history of breast cancer and at least 1 first-, second-, or third-degree relative with ovarian, fallopian tube, or primary peritoneal cancer
- ☐ Individual has a history of breast cancer and belongs to a population at risk for specific mutations due to ethnic or racial background (African American, Ashkenazi Jewish, Icelandic, Swedish, Hungarian, or Dutch descent)
  (If checked, mark all of the following that apply to the individual)
  - ☐ Testing for a specific founder mutation(s) is negative
  - ☐ Individual's ancestry includes more than one ethnicity
  - ☐ Individual meets other BRCA1 or BRCA2 testing criteria
- ☐ Individual has a history of relapsed/refractory human epidermal growth factor receptor 2 (HER2) negative, metastatic breast cancer previously treated with chemotherapy and is a candidate for poly (ADP-ribose) polymerase (PARP) inhibitor therapy

☐ Individual with a **family (no personal) history** of cancer but that relative is NOT available for testing
(If checked, mark the following that apply to the individual for whom the test is being requested)

- ☐ Individual has a first- or second-degree relative who had breast cancer diagnosed at less than or equal to 45 years of age
- ☐ Individual has a first- or second-degree relative with breast cancer diagnosed at any age and that relative has at least one first-, second-, or third-degree relative with breast cancer diagnosed at less than or equal to 50 years of age
- ☐ Individual has a first- or second-degree relative who had multiple primary breast cancers (bilateral [contralateral] disease or two or more separate ipsilateral primary tumors either synchronously or asynchronously
- ☐ Individual has a first or second -degree **male** relative who developed breast cancer
- ☐ Individual has a first- or second-degree relative who had triple negative breast cancer diagnosed at less than or equal to 60 years of age
- ☐ Individual has a first or second-degree relative with breast cancer and that relative has a first-, second-, or third-degree **male** relative with breast cancer
- ☐ Individual has a first- or second-degree relative with a history of breast cancer and 2 or more first-, second-, or third-degree relatives on the same side of the family with pancreatic cancer
- ☐ Individual has a first- or second-degree relative who has a history of ovarian, fallopian tube, or primary peritoneal cancer
- ☐ Individual has a first- or second-degree relative with a history of pancreatic cancer, and a first-, second-, or third-degree relative with breast cancer (diagnosed at less than or equal to 50 years of age) and/or ovarian, fallopian tube, primary peritoneal or pancreatic cancer at any age
- ☐ Individual has a first- or second-degree relative of Ashkenazi Jewish descent with a history of pancreatic cancer
- ☐ Individual has a first- or second-degree relative with history of breast cancer, and that relative has at least 2 or more first-, second-, or third-degree relatives on the same side of the family with breast cancer
- ☐ Individual has a first- or second-degree relative with breast cancer, and that relative has at least 1 first-, second-, or third-degree relative with ovarian, fallopian tube or primary peritoneal cancer
- ☐ Individual has a first- or second-degree relative who has a history of breast cancer and that relative belongs to a population at risk for specific mutations due to ethnic or racial background (African American, Ashkenazi Jewish, Icelandic, Swedish, Hungarian, or Dutch descent)
  (If checked, mark the following that apply to the individual for whom the test is being requested)
  - ☐ Testing for a specific founder mutation(s) is negative
  - ☐ Individual's ancestry includes more than one ethnicity
  - ☐ Individual meets other BRCA1 or BRCA2 testing criteria

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- ☐ Individual has a family history of three or more first-, second-, or third-degree relatives with ovarian, fallopian tube, or primary peritoneal cancer or breast cancer, (at least one of which has breast cancer at or before age 50)
- ☐ Individual requires confirmatory testing for a BRCA1/BRCA2 mutation(s) detected by a Food and Drug Administration (FDA)-authorized direct-to-consumer (DTC) test report

☐ Request is for genetic testing for breast and/or ovarian cancer susceptibility (BRCA1, BRCA2 and/or large genomic rearrangements)

☐ Request is for genetic testing for breast and/or ovarian cancer susceptibility using panels of genes, (with or without next-generation sequencing) including, but not limited to BreastNext™, BREVAGen, or OvaNext™

This request is being submitted:
☐ Pre-Claim
☐ Post–Claim *(If checked, please attach the claim or indicate the claim number)* _____

I confirm that the information entered on this form is accurate and complete based on the records available at the time of this request. I understand the health plan or its designees may request medical documentation to verify the accuracy of the information reported on this form.

_____ _____
Name and Title of Provider or Provider Representative Completing Form and Attestation (Please Print)* Date

***The attestation fields must be completed by a provider or provider representative in order for the tool to be accepted**

Anthem UM Services, Inc., a separate company, is the licensed utilization review agent that performs utilization management services on behalf of your health benefit plan or the administrator of your health benefit plan.