CSHCN Services Program Genetic Testing for Hereditary Breast and/or Ovarian Cancer Prior Authorization Form and Instructions (5 Pages)

Instructions: To request prior authorization for BRCA 1 and BRCA 2 gene analysis mutation testing for breast and/or ovarian cancer, complete the Children with Special Health Care Needs (CSHCN) Services Program Genetic Testing for Hereditary Breast and/or Ovarian Cancer Prior Authorization Form. This form must be completed and signed as outlined in the instructions below. The completed form with the original dated signature must be retained by the requesting physician in the client's medical record. The form is subject to retrospective review.

The following forms, documents, and information must be submitted to request prior authorization:

- ☐ The completed and signed CSHCN Services Program Genetic Testing for Hereditary Breast and/or Ovarian Cancer Prior Authorization Form
- ☐ All medical necessity documentation
- ☐ Attestation for comprehensive testing. The attestation must indicate that familial BRCA testing results could not be obtained. (as necessary)

The completed prior authorization form and all necessary attachments must be submitted to the TMHP CSHCN Services Program Prior Authorization Department by fax to 1-512-514-4222 or by mail at:

Texas Medicaid & Healthcare Partnership
Attention: TMHP-CSHCN Services Program Prior Authorization Department, MC-A11
12357-B Riata Trace Parkway Ste. 100
Austin, TX 78727

Providers can refer to the *CSHCN Services Program Provider Manual* and the Online Fee Schedule (OFL) that are available on the TMHP website at www.tmhp.com for information about procedure codes and prior authorization requirements.

All fields must be filled out completely.

Field	Description
Prior Authorization Request Submitter Certification Statement	
Read the certification statement and select "We Agree."	
Section A: Client Information	
Name:	Enter the client's name as indicated on the client's eligibility card or form.
CSHCN number:	Enter the client's CSHCN number as indicated on the client's eligibility card or form.
Date of birth	Enter the client's date of birth as indicated on the client's eligibility card or form.
Section B: Requested procedure or service information	
Expected dates of service: From / To	Enter the expected date or dates of service for the requested procedure.
Procedure requested – CPT code	Enter the appropriate and most specific procedure code for the service or services being requested.

CSHCN Services Program Genetic Testing for Hereditary Breast and/or Ovarian Cancer Prior Authorization Form and Instructions (5 Pages)

Field	Description
Procedure code description	Enter a brief description of the requested service or services.
Comments:	Enter additional comments if applicable.
Section C: Medical necessity information	
Diagnosis codes:	Enter a valid and appropriate diagnosis code with a brief description.
Medical necessity:	Enter the information about relatives with ovarian or breast cancer. Add additional information as necessary that provides justification to support the medical necessity for the requested service or services. Add additional pages as necessary. **Important:** *All requests for hereditary breast/ovarian cancer genetic testing must meet the National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines.*
Information about close blood relatives from the same side of the family who have been diagnosed with ovarian, breast, prostate (Gleason score of 7 or greater), or pancreatic cancer, or who have had positive BRCA1 or BRCA2 test results with no diagnosis of cancer:	For each relative who has been diagnosed with ovarian or breast cancer, enter the following information: a. Relationship to Client – Enter the relative's relationship to the client. b. Maternal or Paternal - Enter the side of the family who has been diagnosed with cancer (ovarian, breast, prostate or pancreatic). c. Cancer Site – Enter the relative's cancer site. d. Age at diagnosis – Enter the age of each relative when they were diagnosed with ovarian or breast cancer. e. Positive BRCA1 or BRCA2 Results – Check "Yes" if the relative had a positive BRCA1 or BRCA2 test result, or check "No" if the relative had a negative BRCA1 or BRCA2 test result or if no BRCA1 or BRCA2 testing was conducted. **Note:** *A close blood relative includes a 1st (parent, sibling, offspring), 2nd (aunt, uncle, grandparent, niece, nephew, grandchildren, half-sibling), or 3rd (first cousin, great-grandparent, great-aunt, great-uncle, great-grandchildren) degree male or female blood relative from the same side of the family.*
Is testing for known familial variants of BRCA1 or BRCA2 analysis?	Check "no" or "yes" to indicate whether or not the client is being tested because of a known familial variants of BRCA1 or BRCA2 analysis. If "yes," enter the BRCA1 mutation or the BRCA2 mutation in the fields provided.
For full sequence analysis: Positive familial BRCA testing results could not obtained	Check "yes" or "no" to indicate whether or not the positive familial BRCA Testing results could be obtained from the client.

CSHCN Services Program Genetic Testing for Hereditary Breast and/or Ovarian Cancer Prior Authorization Form and Instructions (5 Pages)

Field	Description
Does the client have Ashkenazi Jewish ancestry?	Check "yes" or "no" to indicate whether or not the client is of Ashkenazi Jewish ancestry.
Physician's name:	Enter the physician's name.
Address/City/ZIP:	Enter the physician's office address include city and ZIP code.
Telephone number:	Enter the physician's office contact telephone number.
Fax number:	Enter the physician's office Fax number.
TPI:	Enter the physician's Texas Provider Identifier (TPI).
NPI:	Enter the physician's National Provider Identifier (NPI).
Taxonomy:	Enter the appropriate taxonomy code (if applicable).
Physician's signature:	Sign the form. **Note:** *Signatures from nurse practitioners, physician assistants, and chiropractors will not be accepted. Signature stamps and date stamps are not acceptable.*
Date signed:	Enter the date the physician signed the form.
Section D: Laboratory Provider information	
Provider name:	Enter the name of the facility where the genetic testing will be rendered.
Address/City/ZIP:	Enter the address of the facility including the city and ZIP code.
Contact person:	Enter the name of the contact person at the facility.
Telephone number:	Enter the telephone number of the contact person.
Fax number:	Enter the facility Fax number.
TPI:	Enter the facility Texas Provider Identifier (TPI).
NPI:	Enter the facility National Provider Identifier (NPI).
Taxonomy:	Enter the appropriate taxonomy code (if applicable).

CSHCN Services Program Genetic Testing for Hereditary Breast and/or Ovarian Cancer Prior Authorization Form:

Prior Authorization Request Submitter Certification Statement

I certify and affirm that I am either the Provider, or have been specifically authorized by the Provider (hereinafter "Prior Authorization Request Submitter") to submit this prior authorization request.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that they are personally acquainted with the information supplied on the prior authorization form and any attachments or accompanying information and that it constitutes true, correct, complete and accurate information; does not contain any misrepresentations; and does not fail to include any information that might be deemed relevant or pertinent to the decision on which a prior authorization for payment would be made.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that the information supplied on the prior authorization form and any attachments or accompanying information was made by a person with knowledge of the act, event, condition, opinion, or diagnosis recorded; is kept in the ordinary course of business of the Provider; is the original or an exact duplicate of the original; and is maintained in the individual patient's medical record in accordance with the *CSHCN Services Program Provider Manual*.

The Provider and Prior Authorization Request Submitter certify and affirm that they understand and agree that prior authorization is a condition of reimbursement and is not a guarantee of payment.

The Provider and Prior Authorization Request Submitter understand that payment of claims related to this prior authorization will be from Federal and State funds, and that any false claims, statements or documents, concealment of a material fact, or omitting relevant or pertinent information may constitute fraud and may be prosecuted under applicable federal and/or State laws. The Provider and Prior Authorization Request Submitter understand and agree that failure to provide true and accurate information, omit information, or provide notice of changes to the information previously provided may result in termination of the provider's CSHCN Services Program enrollment and/or personal exclusion from the CSHCN Services Program.

The Provider and Prior Authorization Request Submitter certify, affirm and agree that by checking "We Agree" that they have read and understand the Prior Authorization Agreement requirements as stated in the *CSHCN Services Program Provider Manual* and they agree and consent to the Certification above and to the Texas Medicaid & Healthcare Partnership (TMHP) Terms and Conditions.

☐ We Agree

CSHCN Services Program Genetic Testing for Hereditary Breast and/or Ovarian Cancer Prior Authorization Form:

Section A: Client information

Name:

CSHCN number: | Date of birth:

Section B: Requested procedure or service information

Expected dates of service From: To:

Procedure code requested	Procedure code description

Comments:

Section C: Medical necessity information - Additional pages or documents may be attached as necessary.

Diagnosis codes: | Age of cancer diagnosis (if applicable):

Medical necessity:

Does the client meet the criteria for BRCA1/2 testing as established by the National Comprehensive Cancer Network (NCCN) guidelines? ☐ Yes ☐ No

Information about close blood relatives from the same side of the family who have been diagnosed with ovarian, breast, prostate (Gleason score of 7 or greater), or pancreatic cancer, or who have had positive BRCA1 or BRCA2 test results with no diagnosis of cancer:

Relative	a. Relationship to Client	b. Maternal or Paternal	c. Cancer Site	d. Age at dx	e. Positive BRCA1 or BRCA2 Results
#1:					☐ Yes ☐ No
#2:					☐ Yes ☐ No
#3:					☐ Yes ☐ No

Is testing for known familial variants of BRCA1 or BRCA2 analysis?

☐ No ☐ Yes BRCA1 mutation: BRCA2 mutation:

For full sequence analysis: Positive familial BRCA testing results could not be obtained ☐ Yes ☐ No

Does the client have Ashkenazi Jewish ancestry? ☐ Yes ☐ No

Physician's name:

Address/City/ZIP:

Telephone number: | Fax number:

TPI: | NPI: | Taxonomy:

Physician's signature: | Date signed:

Section D: Laboratory Provider information

Provider name:

Address/City/ZIP:

Contact person:

Telephone number: | Fax number:

TPI: | NPI: | Taxonomy: