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

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 512-514-4222 or by mail at:

Texas Medicaid & Healthcare Partnership
Attention: TMHP-CSHCN Services Program Prior Authorization Department, MC-A11
12365-A Riata Trace Pkwy., 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.

Fields marked with an asterisk below indicate an essential/critical field. If these fields are not completed, your prior authorization request will be returned.

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.
Procedure code description	Enter a brief description of the requested service or services.

Field	Description
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 variant 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.
Does the client have Ashkenazi Jewish ancestry?	Check "yes" or "no" to indicate whether or not the client is of Ashkenazi Jewish ancestry.
Requesting physician's name*:	Enter the physician's name.
Address/City/ZIP:	Enter the physician's office address include city and ZIP + 4 code.
Telephone:	Enter the physician's office contact telephone number.
Fax:	Enter the physician's office Fax number.
NPI*:	Enter the physician's National Provider Identifier (NPI).

Field	Description
Taxonomy:	Enter the appropriate taxonomy code (if applicable).
Benefit Code:	Enter the appropriate benefit code.
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: Rendering Laboratory Provider information	
Rendering 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 + 4.
Contact person:	Enter the name of the contact person at the facility.
Telephone:	Enter the telephone number of the contact person.
Fax:	Enter the facility fax number.
Tax ID*:	Enter the facility Tax Identification Number (TIN).
NPI*:	Enter the facility National Provider Identifier (NPI).
Taxonomy*:	Enter the appropriate taxonomy code (if applicable).
Benefit Code*:	Enter the appropriate benefit code.

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Submit your prior authorization using TMHP's PA on the Portal and receive request decisions more quickly than faxed requests. With PA on the Portal, documents will be immediately received by the PA Department, resulting in a quicker decision. Fax requests must be scanned and data entered before the PA Department receives them, which can take up to 24 hours. To access PA on the Portal, go to www.tmhp.com and select "Prior Authorization" from the Topics drop-down menu. Then click the PA on the Portal button and enter your TMHP Portal Account user name and password. To submit by fax, send to **512-514-4222**.

Note: *If any portion of this form is incomplete, it may result in your prior authorization request being pended for additional information.*

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 *Texas Medicaid Provider Procedures Manual* (TMPPM).

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 Medicaid enrollment and/or personal exclusion from Texas Medicaid.

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 relevant *Texas Medicaid Provider Procedures Manual* and they agree and consent to the Certification above and to the Texas Medicaid & Healthcare Partnership (TMHP) Terms and Conditions.

We Agree

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Note: *Fields marked with an asterisk below indicate an essential/critical field. If these fields are not completed, your prior authorization request will be returned.*

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 at 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 Diagnosis**	**e. Positive BRCA1 or BRCA2 Results**
Relative #1:					Yes No
Relative #2:					Yes No
Relative #3:					Yes No

Is testing for known familial variants of BRCA1 or BRCA2 analysis? Yes No BRCA1 mutation: ________________________ BRCA2 mutation: ________________________	
For full sequence variants: Positive familial BRCA testing results could not be obtained	Yes No
Does the client have Ashkenazi Jewish ancestry? Yes No	

* Essential/Critical field

Section C: Medical necessity information (Additional pages or documents may be attached as necessary)			
Requesting physician's name*:			
Street address:			
City:		State:	ZIP + 4:
Telephone:		Fax:	
NPI*:	Benefit Code:		Taxonomy:
Physician's signature:			Date signed:

Section D: Rendering laboratory provider information			
Rendering provider name*:			
Street address*:			
City:		State:	ZIP + 4*:
Contact person:			
Telephone:		Fax:	
Tax ID*:	NPI*:	Benefit Code*:	Taxonomy*:

* Essential/Critical field