



Prior Authorization Request Form

For Breast and Ovarian Cancer Screening by Molecular Testing

One Monarch Place, Suite 1500, Springfield, Massachusetts 01144-1500 • 413-787-4000 or 800-842-4464

Please PRINT or TYPE Fax completed form to: Health Services Department, HNE: (413) 233-2700

Today's Date: _____

ID#

Patient's Name: _____

Patient's Date of Birth _____

Requesting Physician Information:

Name	Provider #:
Address:	City, State, Zip
Contact Person:	Telephone:
Physician Signature:	Fax:

General Information Regarding Coverage of BRCA 1/2 testing:

HNE covers testing for BRCA 1/2 as recommended by the USPSTF (U.S. Preventive Services Task Force) for a member with an increased risk for deleterious mutations and has participated in a provider-led consent discussion as outlined below and is having the test performed to direct medical management.

REQUIRED Information/Attachments:

- Documentation that the member has participated in informal consent discussions which included discussion of risk factors, possible outcomes of testing, efficacy of early detection methods, and the specific options (the clinical note must be attached).
- The results of this genetic test will alter the medical management of this member. The recommended treatment is (or attach) _____.

Please check all that apply:

- Three or more affected first or second degree relatives on same side of family, irrespective of age at diagnosis or: There are fewer than three affected relatives, but:
 - There are multiple primary or bilateral breast cancers in the patient or one family member, or
 - A family member has been identified with a detectable mutation, or
 - There are one or more cases of ovarian cancer at any age, AND one or more members on the same side of the family with breast cancer at any age, or
 - There is breast cancer in a male patient, or in a male relative, or
 - The patient is at increased risk for specific mutation(s) due to ethnic background (for instance: Ashkenazi Jewish descent) AND has one or more relatives with breast cancer or ovarian cancer at any age, or
 - The patient was diagnosed with breast cancer at 45 years of age or less.
 - The patient did receive appropriate counseling.

Members who seek coverage for BRCA1/2 testing for the benefit of OTHER family members must seek reimbursement of payment from the OTHER family member's insurance carrier. BRCA analysis for the medical management of OTHER family members is not a covered benefit for Health New England members.

By signing this form above, I certify that the member listed above has been given informed consent in accordance with the guidelines and risks above and that the BRCA analysis will be used to direct the medical management of this member. I have included the appropriate documentation.

Please Note: Completion of a Prior Authorization Request Form does not guarantee payment. Payment of covered benefits is subject to the provider's contract, the member's eligibility on the dates of services rendered, and specific provisions of the member's health benefits plan.

FOR HNE USE ONLY

HNE Decision:	<input type="checkbox"/> Approved	<input type="checkbox"/> Denied	Signed: _____	Date: ___/___/___
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