



Phone: (330) 363-7407

Fax: (330) 363-2350

### MOLECULAR DIAGNOSTIC REQUEST

**NOTE: NO MOLECULAR/GENETIC TESTING WILL BE CONSIDERED FOR COVERAGE WITHOUT ALL FIELDS COMPLETE.**

**\*\*\*ALL FIELDS ARE REQUIRED FIELDS.\*\*\***

**MEMBER INFORMATION:**

Date: \_\_\_\_\_ Group Number: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_

ID #: \_\_\_\_\_ DOB: \_\_\_\_\_

**PROVIDER INFORMATION:**

Name of Provider Ordering Testing: \_\_\_\_\_ Tax ID: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

Patient Counseling (Must be completed prior to request):

Name of certified genetic counselor or physician: \_\_\_\_\_

Facility: \_\_\_\_\_ Date of counseling: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**TEST REQUESTED:**

Name of specific test(s) with specific genes to be tested: \_\_\_\_\_

\_\_\_\_\_

CPT Code(s) \_\_\_\_\_

ICD-9 (10) Code(s) \_\_\_\_\_

Laboratory/Facility \_\_\_\_\_ Tax ID: \_\_\_\_\_

Address: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Has the specimen been collected YES \_\_\_ NO \_\_\_ If YES, Date collected: \_\_\_\_\_

Provide the member's personal clinical history that supports the medical necessity of this test. NOTE: Clinical information that supports the medical necessity of the test and pedigree as it relates to the member must be provided by the ordering physician or board certified genetic counselor who is NOT affiliated with the testing lab.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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How will this affect the member's clinical management? Treatment Plan:

Four horizontal lines for writing the treatment plan.

Family history related to ordered tests. Indicate if relationship to member is maternal or paternal (example: Maternal grandmother, maternal cousin, paternal grandfather, etc. )

Relationship: \_\_\_\_\_ Diagnosis: \_\_\_\_\_ Age when diagnosed: \_\_\_\_\_

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**GUIDELINES (Complete policy available upon request):**

- 1. AultCare requires prior authorization for molecular diagnostic testing. Claims that are received without prior authorization will be denied for not having been prior authorized. Failure to obtain prior authorization is a plan design denial and, therefore, it is not subject to medical review.
- 2. AultCare utilizes the InterQual Molecular Diagnostics Criteria (InterQual) when reviewing prior authorization requests for coverage of genetic test. If the specific genetic test is not in the InterQual content, Hayes Technology will be accessed.
- 3. Testing only for the purpose of care or management of the member's family is not covered.
- 4. The requested test is FDA approved.

**BENEFIT OR ORGANIZATION DETERMINATION:**

Members may be eligible under their Plan for genetic testing and counseling to determine the genetic risk of a disease when **documentation is provided by the ordering / treating practioner that supports ALL OF THE FOLLOWING:**

- 1. Counseling is performed with a physician or certified genetic counselor pre-and post-test; **AND**
- 2. The request delineates the diagnosis and specific genes to be tested to establish a diagnosis; **AND**
- 3. Testing is done **ONLY** for those genes deemed medically necessary to establish a diagnosis (Panels are not covered); **AND**
- 4. Alternative diagnostic studies to provide a definitive diagnosis risk for the specific genetic disorder are unavailable or results are ambiguous; **AND**
- 5. The requested test is clinically valid, based on published peer-reviewed medical literature; **AND**
- 6. The member has not had previous genetic testing for the disease; **AND**
- 7. Results of genetic testing must directly impact treatment or management of the member as indicated by a Treatment Plan; **AND**
- 8. The member meets the InterQual criteria; **AND**
- 9. Testing is for the sole care and management of the member only.

SIGNATURE OF PERSON COMPLETING FORM

PRINTED NAME

PHONE

DATE