

**LCA Use Only.**  
Please place  
accessioning  
sticker here.

# Clinical Questionnaire for Hereditary Cancer

Prior authorization questions, call 866-248-1265. / Fax 855-711-5699 / Test questions, call 800-345-4363.

Name and title of person completing this form \_\_\_\_\_

## Test Information (THIS IS NOT AN ORDER FOR A TEST)

**Note:** For Medicare recipients, a signed ABN must accompany the sample if an ICD-10 Code that supports medical necessity is not provided.

ICD-10 Diagnosis Code(s) Required					

BRCAssure® Test Options	Test No.
<input type="radio"/> BRCA1/2 Comprehensive Analysis	252911
<input type="radio"/> BRCA1/2 Ashkenazi Jewish Profile	252970
<input type="radio"/> BRCA1/2 Deletion/Duplication Analysis	252888
<input type="radio"/> BRCA1 Targeted Analysis*	252235
<input type="radio"/> BRCA2 Targeted Analysis*	252250

\*A copy of the positive family member's laboratory report documenting the variant is required for this testing.

VistaSeq® Test Options	Test No.	VistaSeq® Test Options	Test No.
<input type="radio"/> Comprehensive - 27 Genes	481220	<input type="radio"/> Colorectal - 7 Genes	481352
<input type="radio"/> Comprehensive w/o BRCA - 25 Genes	481240	<input type="radio"/> Colorectal - 22 Genes	481363
<input type="radio"/> Breast - 19 Genes	481319	<input type="radio"/> Pancreatic - 14 Genes	481385
<input type="radio"/> Breast - 9 Genes	481452	<input type="radio"/> Endocrine - 13 Genes	481374
<input type="radio"/> Breast & Gyn - 25 Genes	481341	<input type="radio"/> Renal - 19 Genes	481407
<input type="radio"/> Gyn - 11 Genes	481330	<input type="radio"/> Brain/CNS/PNS - 17 Genes	481386

Visit [www.labcorp.com](http://www.labcorp.com) for detailed information on genes included in each panel

## Patient Demographics

Patient's name \_\_\_\_\_ / Date of birth \_\_\_\_\_ / Gender:  Male  Female

Patient's Phone No. \_\_\_\_\_ / Patient's Email \_\_\_\_\_

## Patient History (check all that apply)

- Genetic counseling performed, if marked, attach report Performed by \_\_\_\_\_ Phone \_\_\_\_\_
- Patient had previous hereditary cancer testing, if marked, attach report
- History of bone marrow/stem cell transplant /  History of blood transfusion, date of last transfusion \_\_\_\_\_
- No personal history of cancer
- Breast cancer or DCIS, age at Dx \_\_\_\_\_ (Check all that apply)
- Bilateral  Premenopausal  Triple negative (ER-,PR-,HER2-)
- Ovarian cancer, age at Dx \_\_\_\_\_
- Endometrial cancer, age at Dx \_\_\_\_\_
- Renal cancer, age at Dx \_\_\_\_\_
- Colorectal cancer, age at Dx \_\_\_\_\_
- MSI Results:  High  Low  Stable IHC Results: If present, specify results \_\_\_\_\_
- Pancreatic cancer, age at Dx \_\_\_\_\_
- Prostate cancer, age at Dx \_\_\_\_\_, Gleason Score \_\_\_\_\_,  Metastatic
- Other cancer \_\_\_\_\_, age at Dx \_\_\_\_\_
- Other cancer \_\_\_\_\_, age at Dx \_\_\_\_\_

## Family History (attach additional pages if needed)

Does the patient have Ashkenazi Jewish ancestry?  No  Yes

Unknown or limited family history? Please explain (eg, adopted) \_\_\_\_\_

Relative*	Maternal / Paternal	Cancer Type	Relative Available for Testing? If no, state reason.	Age At Diagnosis	Known Mutation? If yes, attach lab report.
	<input type="checkbox"/> / <input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> / <input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> / <input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> / <input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> / <input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

### Ordering provider understands by signing below:

Pretest counseling, which includes an interpretation of family and medical histories; 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; and counseling for the psychological aspects of genetic testing, has been completed where required by health plan. Post-test counseling will be available.

Account No.: \_\_\_\_\_

Provider Phone No.: \_\_\_\_\_ Fax No. \_\_\_\_\_

Ordering Provider Signature \_\_\_\_\_

Date \_\_\_\_\_

### Patient understands by signing below:

LabCorp may use information obtained on this form and other information provided by me and/or my ordering provider or his/her designee to initiate prior authorization with my health plan as required. I understand a prior authorization approval from my health plan does not guarantee full payment. LabCorp will attempt to contact me if my estimated out-of-pocket cost is more than \$300. Testing may be canceled if LabCorp is unable to reach me. No matter my estimated cost, my actual out-of-pocket cost may be higher or lower than the estimate provided. It is my responsibility to contact my health plan regarding concerns over my coverage and benefits.

If marked, in the event I cannot be reached, LabCorp may leave a confidential voicemail message at the telephone number provided on this form.

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_