Labcorp Use Only. Please place accessioning sticker here.

Clinical Questionnaire for Hereditary Cancer

Prior authorization questions, call **866-248-1265.** / Fax **336-436-1007** / Test questions, call **800-345-4363.**
Email: **PriorAuthEscalations@Labcorp.com**

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.
◯ *BRCA1/2* Comprehensive Analysis	**485030**
◯ *BRCA1/2* Ashkenazi Jewish Profile	**485097**
◯ *BRCA1* Targeted Analysis*	**485066**
◯ *BRCA2* Targeted Analysis*	**485081**

*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.
◯ Hereditary Cancer - 27 Genes	**481220**	◯ High Risk Colorectal – 7 Genes	**481352**
◯ Hereditary Cancer w/o BRCA - 25 Genes	**481240**	◯ Colorectal - 22 Genes	**481363**
◯ Breast - 19 Genes	**481319**	◯ *APC* Single Gene	**483484**
◯ High/Mod Risk Breast – 9 Genes	**481452**	◯ Prostate - 10 Genes	**483555**
◯ Breast & GYN - 25 Genes	**481341**	◯ Pancreatic - 14 Genes	**481385**
◯ GYN - 11 Genes	**481330**	◯ Endocrine - 13 Genes	**481374**
◯ Lynch Syndrome - 5 Genes	**483543**	◯ *MEN1* Single Gene	**483460**
◯ *MLH1* Single Gene	**483496**	◯ *RET* Single Gene	**483472**
◯ *MSH2* Single Gene	**483508**	◯ Renal - 19 Genes	**481407**
◯ *MSH6* Single Gene	**483520**	◯ Brain/CNS/PNS - 17 Genes	**481386**
◯ *PMS2* Single Gene	**483532**	◯ Other_____	

Patient Demographics

Patient's name _____ / Date of birth_____ / Gender: ◯ Male ◯ Female

Patient's phone no. _____ / Patient's email _____

Patient History

Select at least one: ◯ Genetic counseling performed by board-certified genetic counselor or clinical geneticist. If marked, attach genetic counseling report.
◯ Pretest counseling performed by ordering provider or designee in accordance with health plan policies.

Select all that apply:

◯ 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 _____
◯ History of colon polyps, age at Dx _____, Number _____
◯ Pancreatic cancer, age at Dx _____
◯ Prostate cancer, age at Dx _____, Gleason Score _____, ☐ Metastatic
◯ Other cancer _____, age at Dx _____

Family History (attach additional pages if needed)

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.
	◯ / ◯		◯ Yes ◯ No		◯ Yes ◯ No
	◯ / ◯		◯ Yes ◯ No		◯ Yes ◯ No
	◯ / ◯		◯ Yes ◯ No		◯ Yes ◯ No
	◯ / ◯		◯ Yes ◯ No		◯ Yes ◯ No

Genetic Counseling—Ordering provider understands by signing below:
If genetic counseling by a board-certified genetic counselor is required by the health plan prior to laboratory testing but has not occurred as indicated in the Patient History section above, I understand that a referral may be made by the laboratory to a board-certified genetic counselor required or authorized by the health plan such as Informed DNA and Integrated Genetics.
Such referral is solely related to laboratory testing and does not relieve me of any obligation to seek authorization for my services.

Account No.: _____

Provider Name (print): _____ NPI: _____

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**

*Relationships to consider include parents, siblings, offspring (1st degree), half-brothers/sisters, aunts/uncles, grandparents, grandchildren, nieces/nephews (2nd degree); first cousins, great-aunts/uncles, great-grandchildren, great grandparents (3rd degree).

**Visit www.labcorp.com for detailed information on genes included in each panel.

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