ONCOTYPE DX™ REQUEST FORM

Note: This form must be attached to the DDE request, be faxed with a cover sheet to be attached to the DDE request by Kepro or included with a faxed lab request form that is to be keyed by Kepro.

Date: _____

Referring Provider Name: _____

Contact Name: _____ **Telephone Number:** _____

Servicing Provider Name: _____

Member Name: _____

Member Medicaid ID number: _____

Procedure Code Requested: 81519

Does the patient meet ALL of the following criteria?

CRITERIA	YES	NO
Oncotype DX™ is performed within six months of diagnosis		
Node negative(micrometastases less than 2mm in size are considered no negative)		
Hormone receptor positive (ER-positive or PR-positive)		
Tumor size .6-1.0 cm with moderate/poor differentiation or unfavorable features (i.e, angiolymphatic invasion, high nuclear grade, high histologic grade); OR tumor size >1 cm		
Unilateral disease		
Her-2 negative		
Patient will be treated with adjuvant endocrine therapy		
The test result will aid the patient in making a decision regarding chemotherapy when chemotherapy is a therapeutic option		

PATIENT EDUCATION

Client and Physician (prior to testing) have discussed the potential results of the test and agree the results will be used to guide therapy (for example, adjuvant chemotherapy is not recommended with a low-risk score). Use of Oncotype DX™ to determine risk in patients with primary breast cancer who meet criteria above but who have already made the decision to undergo or forego chemotherapy is considered not medically necessary.

This form is required when submitting a request for 81519 ONLY. Please attach the form to the C3 DDE Request if you are able to scan it directly in or you may fax Kepro at 1-844-633-8428 Attn: Medical Unit/ Lab Review Department for the team to attach the document for you to the C3 DDE Request. If you must mail your request, please make a photocopy and send to: Kepro Attn: Medical Unit/ Lab Review Department, 100 Capitol St, Suite 600, Charleston, WV 25301.

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WV MEDICAID MEMBER SIGNATURE **DATE**

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WV MEDICAID ENROLLED ORDERING/REFERRING PROVIDER SIGNATURE **DATE**