Clear Form

hpi Health Plans, Inc.

Preimplantation Genetic Testing (PGT)

Prior Authorization Request Form

This form is to be used by participating providers to request authorization for PGT Services.
Please complete and fax to Care Management Services at 508-756-1382.
If you have any questions about this process, please contact Care Management Services at 866-325-1550.

Requesting MD:	**Tax Identification Number (TIN):**
Genetic Specialist Consultant:	**PGT Laboratory:**

Requested service:

○ **89290** Biopsy, oocyte polar body or embryo blastomere, microtechnique (for preimplantation genetic diagnosis); less than or equal to 5 embryos

○ **89291** Greater than 5 embryos

HPI covers medically necessary PGT (in conjunction with IVF/ICSI) when the member's benefit plan includes coverage for Infertility services and

1. a genetic parent has a balanced reciprocal translocation, or Robertsonian translocation; or
2. a genetic parent is a known carrier of a single gene autosomal dominant disorder listed below; or
3. the female genetic parent is a known carrier of a single gene X-linked recessive disorder listed below; or
4. both genetic parents are known carriers of a listed single gene autosomal recessive disorder.

Please enclose results of any genetic testing and genetic consultant notes/report.

	Genetic Mother	**Genetic Father**
Name:		
Member ID #:		
DOB:		
Pregnancy History:	Gravida: Para: SAB: TAB:	N/A

For members/couples without history of intrauterine pregnancy, include the following test results:

Females:	**Males:**
• Follicle-Stimulatin Hormone [FSH] test and Estradiol levels (Day 3) • Hysterosalpingogram, saline hysterogram, or hysteroscopy performed within the past 4 years	• Semen Analysis performed within the past 12 months

Covered Conditions/Disorders

Condition/Disorder	**Genetic Mother**	**Genetic Father**
Balanced Reciprocal Translocation	☐	☐
Robertsonian Translocation	☐	☐
Single Gene Autosomal Recessive Disorder:	☐ B-Thalessemia Syndromes ☐ Canavan Disease ☐ Cystic Fibrosis ☐ Epidermolysis Bullosa Simplex (autosomal recessive type) ☐ Fanconi Anemia ☐ Familial Dysautonomia ☐ Gaucher Disease ☐ Hurler Syndrome ☐ Metabolic disorders (e.g., methylmalonic acidemia or proprionic academia)	☐ B-Thalessemia Syndromes ☐ Canavan Disease ☐ Cystic Fibrosis ☐ Epidermolysis Bullosa Simplex (autosomal recessive type) ☐ Fanconi Anemia ☐ Familial Dysautonomia ☐ Gaucher Disease ☐ Hurler Syndrome ☐ Metabolic disorders (e.g., methylmalonic acidemia or proprionic academia)

	☐ Sickle Cell Anemia ☐ Spinal Muscular Atrophy Type I ☐ Spinocerebellar Ataxia (autosomal recessive type) ☐ Tay-Sachs Disease	☐ Sickle Cell Anemia ☐ Spinal Muscular Atrophy Type I ☐ Spinocerebellar Ataxia (autosomal recessive type) ☐ Tay-Sachs Disease
Condition/Disorder	**Genetic Mother**	**Genetic Father**
Single Gene Autosomal Dominant Disorders	☐ Epidermolysis Bullosa (autosomal dominant type) ☐ Huntington's Disease ☐ Marfan's Syndrome ☐ Myotonic Dystrophy ☐ Neurofibromatosis Type I & II ☐ Retinoblastoma ☐ Spinocerebellar Ataxia (autosomal dominant type) ☐ Tuberous Sclerosis	☐ Epidermolysis Bullosa (autosomal dominant type) ☐ Huntington's Disease ☐ Marfan's Syndrome ☐ Myotonic Dystrophy ☐ Neurofibromatosis Type I & II ☐ Retinoblastoma ☐ Spinocerebellar Ataxia (autosomal dominant type) ☐ Tuberous Sclerosis
Single Gene X-Linked Recessive Disorders	☐ Adrenoleukodystrophy ☐ Alport Syndrome ☐ Becker Muscular Dystrophy ☐ Choroideremia ☐ Duschene Muscular Dystrophy ☐ Fabry's Disease ☐ Fragile X Syndrome ☐ Hemophilia A & B ☐ Hunter Syndrome ☐ Lesch-Nyhan Syndrome ☐ X-linked Mental Retardation	N/A
Other (please specify):		

Form completed by (*please print*):	
Name:	**Fax:**
Phone:	**Date:**