Whole Exome Sequencing Recommendation Form

This form, along with a three-generation pedigree, copy of the ordering health care professional's laboratory requisition form, and a copy of your genetics evaluation documentation are required for consideration of this request. **Please fax the completed form and required copies to Cigna at 1.855.245.1104.**

Note: This form should only be used for whole exome sequencing (WES) recommendations. A separate request form for all other genetic testing recommendations is available on Cigna.com.

Customer (patient) information

Name:
Cigna customer ID:
Date of birth:
Date of consultation:

Ordering health care professional information

Name:	Taxpayer Identification Number (TIN):
Street address:	Telephone:
City, State ZIP:	Fax:
Specialty:	

Clinical geneticist, genetic counselor, advanced genetics nurse (AGN-BC), genetic clinical nurse (GCN), or advanced practice nurse in genetics (APNG) information (if different from above)

Name:	
Street address:	Telephone:
City, State ZIP:	Fax:

Rendering laboratory information

Name:	Taxpayer Identification Number (TIN):
Street address:	Telephone:
City, State ZIP:	Fax:

Diagnosis codes

List ICD-10 codes here:

Requested test information

Test name:	**CPT code(s):**	**List price:**

Patient's phenotype is likely genetic as demonstrated by EITHER of the following:

❑ Multiple abnormalities affecting unrelated organ systems (please specify):

_____

_____

OR TWO of the following FOUR criteria are met:

❑ Abnormality affecting a single organ system (please specify):

_____

_____

❑ Significant intellectual disability, symptoms of a complex neurodevelopmental disorder (e.g., self-injurious behavior or reverse sleep-wake cycles), or severe neuropsychiatric condition (e.g., schizophrenia, bipolar disorder, Tourette syndrome).

❑ Family history strongly implicating a genetic etiology (please specify findings and degree of relationship):

_____

_____

❑ Period of unexplained developmental regression (unrelated to autism or epilepsy).

List of differential diagnoses

Diagnosis:	**Key gene(s) of interest:**

Proposed changes to medical management specific to this patient based on WES results

Recommended genetic tests if WES is NOT performed

Name:	**List price:**

Recommended follow-up procedures if WES is NOT performed

Name:	**Frequency:**

Please initial below:

_____**I attest there is no clinically available single gene or panel test that adequately addresses my patient's symptoms.**

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Recommendation (choose one of the following):

	This individual meets Cigna's Medical Coverage Policy criteria, and I support the testing requested.
	This individual does not meet Cigna's Medical Coverage Policy criteria, but I support the testing requested for the reason(s) listed below (indicate alternate best-practice guidelines that support your recommendation).
	I do not support the recommendation, but do recommend consideration of the following alternative testing (provide explanation below).
	This individual does not meet Cigna's Medical Coverage Policy criteria for the testing requested, and I recommend no genetic testing be performed at this time.
	This individual does NOT meet Cigna's Medical Coverage Policy criteria and has elected NOT to pursue testing at this time (provide explanation below).
	This individual does meet Cigna's Medical Coverage Policy criteria but has elected NOT to pursue testing at this time for reasons outlined below.
	I have no recommendation to make regarding the testing requested for the reason(s) described below.
	Reasons or explanation:

	By checking this box, I affirm that I am a genetic clinical nurse (GCN), advanced practice nurse in genetics (APNG), board-certified genetic counselor, board-eligible or board-certified clinical geneticist, or have been specifically credentialed by Cigna to perform genetic counseling, and I am not currently employed by a genetic testing laboratory.
	By checking this box, I confirm I have attached a three-generation pedigree, copy of the ordering health care professional's lab requisition form, and a copy of my genetic evaluation documentation. I understand authorization may be denied if all documentation is not received.

Signature

Signature:	Date: