Whole Exome Sequencing and Whole Genome Sequencing Recommendation Form

CLEAR 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 OR whole genome sequencing recommendations. A separate request form for all other genetic testing recommendations is available on Cigna.com.

Customer (Patient) Information

Customer (Patient) name:	Cigna Customer ID:	Date of Birth:	Date of Consultation:

Ordering Health Care Professional Information

Professional name:	Tax Identification Number (TIN):

Street address *(street, PO Box, suite)*:

City:	State:	Zip Code:

County:	Phone number:	Fax number:
	( )	( )

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)*

Professional name:	

Street address *(street, PO Box, suite)*:

City:	State:	Zip Code:

County:	Phone number:	Fax number:
	( )	( )

Rendering Laboratory Information

Professional name:	Tax Identification Number (TIN):

Street address *(street, PO Box, suite)*:

City:	State:	Zip Code:

County:	Phone number:	Fax number:
	( )	( )

Diagnosis Codes

List ICD-10 codes here

Requested Test Information

Test category *(please check ONE)*:	Proprietary test name:	CPT code(s):
☐ Whole exome sequencing		
☐ Whole genome sequencing		

Patient Phenotype Indicators

Please select all of the indications that apply below:

☐ **Patient's phenotype is likely genetic as demonstrated by ANY of the following** *(please select ALL of the applicable indications below):*

- ☐ individual with multiple major structural or functional congenital anomalies affecting unrelated organ systems, including metabolic disorders
- ☐ individual with one major structural congenital anomaly and two or more minor structural anomalies
- ☐ individual with at least two of the following:
  - ☐ major structural congenital anomaly affecting a single organ system
  - ☐ neurological features including at least two of the following:
    - ☐ autism
    - ☐ severe psychological/psychiatric disturbance *(e.g., self-injurious behavior, reversed sleep-wake cycles)* or severe neuropsychiatric condition *(e.g., schizophrenia, bipolar disorder, Tourette syndrome)*
    - ☐ symptoms of a complex neurodevelopmental disorder *(e.g., dystonia, ataxia, alternating hemiplegia, neuromuscular disorder)*
  - ☐ family history strongly implicating a genetic etiology
  - ☐ period of unexplained developmental regression (unrelated to autism or epilepsy)

☐ **Epilepsy:**
individual with known or suspected developmental and epileptic encephalopathy (onset before three years of age) for which likely non-genetic causes of epilepsy *(e.g. environmental exposures; brain injury secondary to complications of extreme prematurity, infection, trauma)* have been excluded

☐ **Hearing Loss:**
individual with confirmed bilateral sensorineural hearing loss of unknown etiology

☐ **Global developmental delay:**
individual diagnosed with global developmental delay* following formal assessment by a developmental pediatrician or neurologist

☐ **Intellectual disability:**
individual diagnosed with moderate/severe/profound intellectual disability** following formal assessment by a developmental pediatrician or neurologist

Patient Phenotype Indicators *(cont'd)*

Please select all of the indications that apply below:

☐ **Fetal testing, when ALL of the following criteria are met (***please select ALL of the applicable indications below)*:

- ☐ standard diagnostic genetic testing *(chromosomal microarray analysis (CMA) and/or karyotype)* of the fetus has been performed and is uninformative
- ☐ testing is performed on direct amniotic fluid/chorionic villi, cultured cells from amniotic fluid/chorionic villi or DNA extracted from fetal blood or tissue
- ☐ at least one of the following is present:
  - ☐ multiple fetal structural anomalies affecting unrelated organ systems
  - ☐ fetal hydrops of unknown etiology
  - ☐ a fetal structural anomaly affecting a single organ system and family history strongly suggests a genetic etiology

* Global developmental delay is defined as significant delay in younger children, under age five years, in at least two of the major developmental domains: gross or fine motor; speech and language; cognition; social and personal development; and activities of daily living.

** Moderate/severe/profound intellectual disability as defined by Diagnostic and Statistical Manual of Mental Disorders (DSM-5) criteria, diagnosed by 18 years of age.

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: **Date:**