

Idaho Medicaid 81519 Oncotype Lab Prior Authorization Form
Fax to: (877) 314-8779

Date Faxed to Medicaid:

Proposed Date(s) of Service:

Medicaid Participant Information

Last Name:

First Name:

Initial:

Medicaid ID Number:

Date of Birth:

Physician Information

Physician Name:

Phone:

Address:

Lab Provider Information

Provider Name:

NPI:

Contact Name:

Phone:

Email:

Diagnosis Information

Diagnosis:

Tumor Stage:

0 I IIA IIB IIIA IIIB IIIC IV

Tumor Size:

< 0.5cm 0.5cm-2cm 2cm-5cm > 5cm

Regional Lymph Node Status:

No metastases identified
 Tumor cells or micrometastases < 2mm
 At least 1 positive node with metastasis > 2mm

HER2 Status:

Positive Negative Equivocal Unknown

ER Status:

Positive Negative Unknown

PR Status:

Positive Negative Unknown

Required Documentation

Has the physician and member discussed the potential results of the test and agreed that the results will be used to guide therapy (e.g., forgo adjuvant chemotherapy in the event of a low-risk score)?

Yes No

Please fax all medical documentation that supports medical necessity. For example, physician notes, surgery reports and/or medical records within the last six months.

Physician Signature: _____ Date: _____

For questions regarding authorization number, requirements, limitation or status, call Molina Customer Service at 1 (866) 686-4272 or see the Molina HealthPAS portal at www.idmedicaid.com.