**LETTER OF MEDICAL NECESSITY TEMPLATE ADENOMATOUS POLYPOSIS GENETIC TESTING (*APC* and *MUTYH* analyses)**

Date: Date of service/claim

To: Utilization Review Department

Insurance Company Name, Address, City, State

Re: Patient Name, DOB, ID #

Commonly Used ICD-10 Codes for Hereditary Cancer Testing: (Quick reference guide – provider is responsible for selecting most appropriate code(s) based on individual assessment of the patient)

ACTIVE DIAGNOSIS:

C18.9 COLON cancer K36.5 Colon POLYPS Q14.1 CHRPE

D48.1 Desmoid tumor C22.2 Hepatoblastoma

C73 Papillary thyroid cancer PERSONAL HISTORY:

Z83.71 COLON cancer. Personal history Z86.010 Colon POLYPS, Personal history Z86.03 Desmoid tumor, Personal history Z85.05 Hepatoblastoma, Personal history

Z85.850 Papillary thyroid cancer, Personal history FAMILY HISTORY:

Z80.0 COLON (digestive organ) cancer, Family history Z83.71 Colon POLYPS, family history

This letter is regarding my patient and your subscriber, referenced above, to request full coverage of medically indicated genetic testing for adenomatous polyposis (*APC* and/or *MUTYH* analyses) to be performed by Ambry Genetics Corporation.

Familial adenomatous polyposis (FAP) and *MUTYH*-associated polyposis (MAP) are related conditions that predispose individuals to developing as many as hundreds to thousands of adenomatous colorectal polyps and a high risk for colorectal cancer. **Significant aspects of my patient’s personal and/or family medical history that suggest a reasonable probability of FAP/MAP are below:** [check all that apply]

 Colon cancer

 10 or more cumulative GI adenomatous polyps during their lifetime

 Multifocal congenital hypertrophy of retinal pigment epithelium (CHRPE)

 Desmoid tumor

 Hepatoblastoma

 Papillary thyroid cancer (cribriform-morular variant)

 Close relative with FAP/MAP, unable to undergo genetic testing.

 Other:

Based on the personal and/or family history, my patient is suspicious for FAP/MAP. **According to published guidelines, germline genetic testing is warranted.**1

This genetic testing will help estimate my patient’s risk to develop [choose one] cancer/another primary cancer and **could directly impact my patient’s medical management.** The genes in this test have **published clinical practice guidelines** to reduce the risk for cancer and/or detect cancer early, in order to reduce morbidity and mortality. Management options may include2,3 [check all that apply]:

 Earlier and/or more frequent colonoscopy

 Colectomy

 Upper endoscopy

 Consideration of annual thyroid ultrasound examination

 Other:

[For affected patients:] This testing may also impact the surgical and/or medical options available to treat my patient’s current cancer.

Based on these factors, this testing is medically necessary, and I request that you approve coverage of genetic testing for FAP/MAP in my patient.

Thank you for your time, and please don’t hesitate to contact me with any questions. Sincerely,

Ordering Clinician

**Test Details**

CPT codes: 81201, 81406 or 81479

Laboratory: Ambry Genetics Corporation (TIN 33-0892453 / NPI 1861568784), a CAP-accredited and CLIA- certified laboratory located at 7 Argonaut, Aliso Viejo, CA 92656

References:

1. NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®). Genetic/Familial High-Risk Assessment: Colorectal, Endometrial and Gastric. Version 1.2025, 06/13/2025.