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ExomeNext Medical Necessity Form

REQUIRED FOR INSURANCE ORDERS ONLY (NOT REQUIRED FOR CIGNA MEMBERS)

This form is required if you are ordering Exome testing and wish to have the patient's insurance billed. Please complete and submit with the TRF and a copy of clinical notes. This form replaces the Letter of Medical Necessity.

1. Has the patient had previous Whole Exome Sequencing (WES) performed?

   ☐ Yes, date performed: _____

   ☐ No

2. Does this patient have a clinical presentation consistent with the following (select all that apply):

   ☐ Multiple abnormalities affecting unrelated organ systems (please specify): _____

   OR two of the following:

   ☐ Abnormality affecting a single organ system (specify): _____

   ☐ Significant intellectual disability, symptoms of a complex neurodevelopmental disorder (i.e. self-injurious behavior, reverse sleep-wake cycle, or seizure/epilepsy), or severe neuropsychiatric condition (e.g. schizophrenia, bipolar, Tourette syndrome)

   ☐ Family history strongly implicating a genetic etiology (please specify findings and relationships): _____

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

3. Are the results of this WES test expected to directly influence this patient's medical management recommendations and clinical outcome?

   ☐ Yes (please describe): _____

   ☐ No

4. Please describe the genetic tests that would be indicated if WES were NOT performed (i.e., single gene tests, gene panels, etc.):

   ☐ Chromosomal microarray

   ☐ Single gene test(s): _____

   ☐ Multigene panel(s): _____

   ☐ Other genetic test(s): _____

5. Please describe follow-up procedures & frequency that would be needed if WES were NOT performed (i.e., lumbar puncture, imaging studies, brain MRI, etc.):

   ☐ Imaging study: _____

   ☐ Surgery: _____

   ☐ Biopsy: _____

   ☐ Other: _____

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