



STATEMENT OF MEDICAL NECESSITY for Oncotype Dx

Codes: S3854 and 84999

FAX Completed form to: 1 (800) 453-4341

PATIENT INFORMATION

Name:			
Date of Birth:	Gender:	<input type="checkbox"/> Female <input type="checkbox"/> Male	Group#
Member ID#			

PHYSICIAN INFORMATION

Name:
Address:
Phone Number:

MEDICAL CRITERIA (Please complete each item)

Unilateral, non-fixed tumor (i.e. tumor not adhered to the chest wall) Yes: <input type="checkbox"/> No: <input type="checkbox"/>
Node Status: _____
(Note: Lymph nodes with only micrometastases are not considered positive)
Estrogen Receptor Status: _____
Progesterone Receptor Status: _____
HER2 Receptor Status: _____
Tumor Size: _____
Tumor Differentiation or Unfavorable Feature(s): _____
Please see Medical Policy Assays of Genetic Expression in Tumor Tissue as a Technique to Determine Prognosis In Patients With Breast Cancer, at http://blue.regence.com/trgmedpol/lab/lab42.html for details.
I certify that my patient will benefit from a personalized genomic analysis of the tumor. I have discussed with the patient the potential results for the test and agree that the results once received will be used to guide therapy. A treatment decision regarding the use of adjuvant chemotherapy has not been determined at this time.
Physician's Signature:
Date: