LETTER OF MEDICAL NECESSITY

PHARMACOGENOMIC (PGX) TESTING

Patient Name: _____ Patient Date of Birth: _____/_____/_____

Date of Service: _____/_____/_____ ICD-10 Diagnosis Codes: _____

DEAR CLAIMS SPECIALIST:

Please consider this Letter of Medical Necessity a formal request for full coverage of the pharmacogenomic testing services that I intend to prescribe for your subscriber (Patient Name Listed above). Pharmacogenomic testing laboratory services will be performed by Genemarkers, a CLIA-certified laboratory (NPI# 1770909319), and the results will assist me in making patient-specific clinical decisions regarding the medical management of your subscriber.

To provide the safest, most effective and affordable medical care possible, the requested genetic testing is medically necessary for my patient for several reasons. The primary reason(s) for my request apply specifically to the patient listed above:

___ Determine Drug-Gene interactions, better predicting how the patient will metabolize medications
___ Determine Drug-Drug interactions based on the patient's genetic-determined phenotype
___ Reduce the number of medications that my patient is currently taking
___ Determine the potential effectiveness of medications prescribed to my patient
___ Determine the best course of therapy for my patient
___ Acquire specific dosing recommendations to avoid toxicity and adverse drug reactions (ADR's)
___ Patient has a family history of thrombosis
___ Patient is not responding to the drugs he/she has been prescribed
___ Patient has suffered recent or previous Severe Adverse Drug Reactions (SADR)
___ Other (please specify): _____

ADDITIONAL CLINICAL INFORMATION:

Previously failed medication(s): _____

Currently failing medication(s): _____

Proposed new medication(s): _____

SADR symptoms/presumed associated medication: _____

SEE ATTACHED CLINICAL NOTES FROM DATE OF SERVICE

Progress notes for date of service include clinical reason for ordering PGX test and medication list.

The FDA recommendations for genetic testing are currently listed on the labels of over 150 prescription medications. Please visit (http://www.fda.gov/drugs/scienceresearch/researchareas/pharmacogenetics/ucm083378.htm) for more information. Recommendations typically include pharmacologic treatment contraindications and dose-selection strategies based on patient genetic status. As a health-care prescriber, I am obligated to provide the best medical care possible for my patients. Medical management based on patient-specific pharmacogenomic testing can improve clinical outcomes and PREVENT unnecessary suffering and costs.

Billing for genetic testing services will be initiated upon completion of services. As completion of genetic testing can take several months, **I am requesting your authorization be valid for 6 months.**

Best regards,

Name of Practice: _____

Ordering Clinician Signature: _____ Date: _____/_____/_____

MD/DO, Clinical Nurse Specialist, Nurse-Midwives, Nurse Practitioner, Physician Assistant, Genetic Counselor
(Clinician prescribing requirements vary by state)