



Regence BlueShield is an Independent Licensee of The Blue Cross and Blue Shield Association

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: Female <input type="checkbox"/> Male <input type="checkbox"/>	Group #:
Member ID#:		

Physician Information

Name:
Address:
Phone Number:

Medical Criteria (Please complete each item)

<p>Unilateral, non-fixed tumor (i.e., tumor not adhered to the chest wall) Yes: <input type="checkbox"/> No: <input type="checkbox"/></p> <p>Node Status: _____</p> <p>(Note: Lymph nodes with only micrometastases are not considered positive)</p> <p>Estrogen Receptor Status: _____</p> <p>Progesterone Receptor Status: _____</p> <p>HER2 Receptor Status: _____</p> <p>Tumor Size: _____</p> <p>Tumor Differentiation or Unfavorable Feature(s): _____</p> <p>_____</p> <p>Please see Regence 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/geneticTesting/gt42.html for details.</p> <p>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.</p> <p>Physician's Signature: _____ Date: _____</p>
