



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)

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 <i>Assays of Genetic Expression in Tumor Tissue as a Technique to Determine Prognosis In Patients With Breast Cancer</i> , at http://blue.regence.com/trgmedpol/geneticTesting/gt42.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: _____