THE OHIO STATE UNIVERSITY
HEALTH PLAN

**Email completed form to:**
UtilizationManagement.OSUHealthPlan@osumc.edu
**or fax to: (614) 292-2667**

# Cell-Free Fetal Nucleic Acids Maternal Blood Test Authorization Form

**Patient Information**

| |
|---|
| Patient Name: |
| Member ID #: |
| DOB: |

**Requesting Provider Information**

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|---|
| Physician Name: |
| Office Contact Name: |
| Phone #: |
| Fax #: |

**Performing Provider Information**

| | | |
|---|---|---|
| Provider Name:<br>Contact Name: | TIN:<br>NPI: | |
| Address: | | |
| City: | State: | Zip: |
| Phone #: | Fax #: | |

| **Date of Service:** | **Diagnosis [ICD-10-CM]:** | **Name of Test and CPT Code(s):** |
|---|---|---|
| | | |

Is this a single gestation pregnancy? ☐ Yes ☐ No

Please choose at least one of the following indications and provide supporting documentation when applicable:

- ☐ Fetal ultrasonographic findings predicting an increased risk of fetal aneuploidy; or
- ☐ History of a prior pregnancy with an aneuploidy; or
- ☐ Parental balanced robertsonian translocation with increased risk for fetal trisomy 13 or trisomy 21; or
- ☐ Positive screening test for an aneuploidy, including first trimester, sequential, or integrated screen, or a positive quadruple screen; or
- ☐ Pregnant women age 35 years and older at expected time of delivery; or
- ☐ Pregnant women who exhibit soft markers of aneuploidy (e.g., absent or hypoplastic nasal bone, choroid plexus cyst, echogenic bowel, echogenic intracardiac focus, mild fetal pyelectasis, and shortened femur or humerus)

The OSU Health Plan considers measurement of cell-free DNA experimental and investigational for fetal genotyping for RHD (Sensigene), and for other indications not listed above because its effectiveness has not been established for other indications.

**Requesting Physician Signature:** _____ **Date:** _____

The form should be completed by the clinician who has a thorough knowledge of the member's current clinical presentation and his/her treatment history. Please complete all parts as clearly and specifically as possible. Omissions, generalities and illegibility will result in the form being returned for completion or clarification.

**For questions, please contact The OSU Health Plan at 614-292-4700.**

**HEALTH PLAN USE ONLY:**

| | |
|---|---|
| **Authorization #:** | **Date Span:** |
| **Approved by:** | **Phone #:** |
| **Comments:** | |