TO: **Physicians, Advanced Practice Registered Nurses (APRNs), Physician Assistants (PAs), Certified Nurse Midwives, Clinics, Hospitals and Laboratories**

RE: **New Non-invasive Prenatal Testing for Fetal Aneuploidy Prior Authorization Request Form**

Effective February 1, 2019, providers are required to submit requests for non-invasive fetal aneuploidy testing using the newly created ***Non-invasive Prenatal Testing for Fetal Aneuploidy Prior Authorization Request Form.***

This form is available on the HUSKY Health Web site at: www.ct.gov/husky. To access the form, click on ***For Providers***, followed by ***Prior Authorization Forms and Manuals*** under the ***Prior Authorization*** menu item.

Prior Authorization Submission Process

There are no changes to the prior authorization (PA) submission process. Providers must fax the completed and signed prior authorization form to Community Health Network of Connecticut, Inc. (CHNCT) at (203) 265-3994.

For questions regarding the PA process, please contact CHNCT at 1-800-440-5071, Monday through Friday, between the hours of 8:00 a.m. to 6:00 p.m.

HUSKY Health Program
Non-invasive Prenatal Testing for Fetal Aneuploidy Prior Authorization Request Form

This form MUST be completed and signed by the ORDERING PROVIDER.
The LABORATORY must then fax the form to 203.265.3994.
Phone: 1.800.440.5071

Member Information		
Member ID #:	DOB:	Member Name (Last, First):
Address:		City, State, Zip:

Requested Testing	
CPT Code:	Date of Service:
Diagnosis (ICD-10 CM) Code(s):	EDC:

The patient has a ***singleton pregnancy*** determined to be at increased risk of fetal aneuploidy (trisomy 21, 18, or 13) due to one or more of the following:

1. Maternal age of 35 years of age and older at time of delivery	□ Yes	□ No
2. Fetal ultrasound findings indicating an increased risk of aneuploidy	□ Yes	□ No
3. History of prior pregnancy with a trisomy	□ Yes	□ No
4. Positive first or second trimester screening test results for aneuploidy	□ Yes	□ No
5. Parental balanced Robertsonian translocation with a risk of fetal trisomy 13 or trisomy 21	□ Yes	□ No
The risks and benefits of non-invasive fetal aneuploidy testing have been discussed with the patient and a plan to discuss findings post-testing is in place.	□ Yes	□ No

Note: Review criteria are used as guidelines only. Determinations are based on a person-centered assessment of the individual and their unique clinical needs. Additional information submitted with this request will be considered as part of the medical necessity review process, in accordance with Conn. Gen. Stat. Sec. 17b-259b.

Billing Provider Information		
Medicaid Billing Number:		Billing Provider Name:
Street Address:		City, State, Zip:
Phone #:	Fax #:	Contact Name:

Ordering Provider Information		
Medicaid Billing Number:		Ordering Provider Name:
Street Address:		City, State, Zip:
Phone #:	Fax #:	Contact Name:

Certification Statement: This is to certify that the requested testing is medically indicated and is reasonable and necessary for the treatment of this patient and that a prescribing practitioner signed order is on file. This form and any statement on my letterhead attached hereto has been completed by me or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil and criminal liability.

Physician Signature:	**Date:**