

Oncotype DX™ Request Form

Member Name	Member ID
Requesting Physician	Contact Name
Phone Number ()	Fax Number ()

The member named above has requested coverage of Oncotype DX™.

BCBSNC will provide coverage for Oncotype DX™ when the criteria shown below are met.

Patient has early stage (stage 1 or 2) breast cancer; and	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Oncotype DX™ is the gene expression profile panel used; and	Yes <input type="checkbox"/>	No <input type="checkbox"/>
The results will aid the patient in deciding whether or not to undergo adjuvant chemotherapy; and	Yes <input type="checkbox"/>	No <input type="checkbox"/>
The patient will be treated with hormonal therapy; and	Yes <input type="checkbox"/>	No <input type="checkbox"/>
The patient's breast cancer meets <u>all</u> of the following criteria:		
Unilateral non-fixed	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Estrogen receptor-positive <u>OR</u> progesterone receptor-positive	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Node-negative – pN0, pN0i+, or pN1mi (isolated tumor cells and/or micrometastases are not considered positive for this purpose)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Her-2 negative	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Tumor size is >0.5-1cm (pT1b) with moderate/poor differentiation or unfavorable features, <u>OR</u> tumor size is >1cm (pT1c or pT2); and	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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The test is being ordered by the physician that will be administering the hormonal and/or chemotherapy to the patient based on the test results (this will usually be the oncologist)

Yes

No

BCBSNC does not provide coverage for Oncotype DX™:

- ◆ When the above criteria are not met.

By signing below, I certify that the information on this form accurately reflects the contents of the medical records that I have on the above-referenced patient. I understand that I may be asked to provide these medical records upon request.

Physician signature: _____

Date: _____

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