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Clinical Questionnaire for Maturity-Onset Diabetes of the Young (MODY)

Prior authorization questions, call **866-248-1265.** / Fax **336-436-1007** / Test questions, call **877-436-3056.**

Email **PriorAuthEscalations@Labcorp.com**

Name and title of person completing this form _____

Test Information (this is not an order for a test)

Note: For Medicare recipients, a signed ABN must accompany the sample if an ICD-10 Code that supports medical necessity is not provided.						
ICD-10 Diagnosis Code(s) Required						

Test Name	Test No.	Test Information
◯ **Maturity-Onset Diabetes of the Young (MODY) 4-Gene Panel**	**630568**	**Use:** Detect mutations and copy number variants in the coding sequence and exon-intron junctions of the MODY genes in the ADA guidelines: *HNF1A, GCK, HNF4A* and *HNF1B*. **Methodology:** Next Generation Sequencing
◯ **Maturity-Onset Diabetes of the Young (MODY) Expanded Genetic Panel**	**630513**	**Use:** Detect mutations and copy number variants in the coding sequence and exon-intron junctions of the following genes: *ABCC8, APPL1, GCK, HNF1A, HNF1B, HNF4A, INS, KCNJ11, NEUROD1* and *PDX1*. **Methodology:** Next Generation Sequencing

Patient Demographics

Patient's name _____ / Date of birth_____ Sex assigned at birth:

Patient's Phone No. _____ / Patient's Email_____ ◯ Male ◯ Female

Patient History (check all that apply)

◯ **Hyperglycemia,** age at Dx _____ / ◯ **Diabetes,** age at Dx _____ / ◯ **Acanthosis nigricans**

Height _____ / **Weight**_____ / **and/or BMI**_____ / **HbA1c (%)**_____

◯ **Tested for diabetes autoantibodies,** select which antibodies were positive:

☐ GAD-65 ☐ ICA 512 ☐ IAA (Insulin autoantibodies) ☐ ZnT8 antibodies ☐ 1A-2A ☐ None were positive

◯ **Extra-pancreatic manifestations (eg, congenital malformations and other signs of syndromic diabetes)**

◯ **Previous MODY genetic testing; if marked, attach report**

Family History (attach additional pages if needed)

◯ Unknown or limited family history? Please explain (eg, adopted) _____

Relative*	Maternal / Paternal	Diabetes Type	Age At Diagnosis	Known MODY Mutation? If yes, attach lab report.
	◯ / ◯			◯ Yes ◯ No
	◯ / ◯			◯ Yes ◯ No
	◯ / ◯			◯ Yes ◯ No
	◯ / ◯			◯ Yes ◯ No
	◯ / ◯			◯ Yes ◯ No

Ordering provider understands by signing below:
Pretest counseling, which includes an interpretation of family and medical histories; education about inheritance, genetic testing, disease management, prevention, and resources; counseling to promote informed choices and adaptation to the risk or presence of a genetic condition; and counseling for the psychological aspects of genetic testing, has been completed where required by health plan. Post-test counseling will be available.

Account No.: _____

Provider Phone No.: _____ Fax No. _____

_____ / _____
Ordering Provider Signature **Date**

Patient understands by signing below:
Labcorp may use information obtained on this form and other information provided by me and/or my ordering provider or his/her designee to initiate prior authorization with my health plan as required. I understand a prior authorization approval from my health plan does not guarantee full payment. Labcorp will attempt to contact me if my estimated out-of-pocket cost is more than $300. Testing may be canceled if Labcorp is unable to reach me. No matter my estimated cost, my actual out-of-pocket cost may be higher or lower than the estimate provided. It is my responsibility to contact my health plan regarding concerns over my coverage and benefits.

◯ **If marked, in the event I cannot be reached, Labcorp may leave a confidential voicemail message at the telephone number provided on this form.**

_____ / _____
Patient Signature **Date**

*Relationships to consider include parents, siblings, offspring (1st degree), half-brothers/sisters, aunts/uncles, grandparents, grandchildren, nieces/nephews (2nd degree); first cousins, great-aunts/uncles, great-grandchildren, great grandparents (3rd degree).

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