

## Oncotype DX

**Assays of Genetic Expression in Tumor Tissue as a Technique to Determine Prognosis in Patients with Breast Cancer  
Medical Policy – MED207.130**

Please complete all appropriate questions fully.

Suggested medical record documentation:

- Pathology report

\*Failure to include suggested medical record documentation may result in delay or possible denial of request.

**Note:** For Predetermination, please fully complete and submit the [Predetermination Request Form](#).

**PATIENT INFORMATION**

Name:

Date of Birth:

Gender:

- Female  Male

Group ID

Member ID

**MEDICAL CRITERIA (Please check all applicable boxes)**

- Unilateral, non-fixed tumor
- Tumor size of either > 1cm, or .6-1cm with moderate or poor differentiation or unfavorable features **(pathology report required)**
- Breast cancer will be treated with hormonal therapy
- Tumor is non-metastatic and lymph node negative
- Estrogen Receptor or Progesterone Receptor positive
- HER2 negative

By signing below, I certify that surgery and subsequent pathology examination of the tumor has been completed, **AND**

I certify that I am the oncologist caring for the patient, **AND**

I certify that I have discussed with the patient how the results of this test will be used to guide the patient in decision-making on chemotherapy, and that the test is being ordered for that purpose.

Physician's Signature:

Date:

*Revised 06/2009*