Medical Necessity Documentation for *TGFBI* Corneal Dystrophies Testing

PATIENT FIRST NAME _____ LAST NAME _____

DATE OF BIRTH _____

TEST RATIONALE

This test(s) was ordered for the patient named above for the following reason(s):

- ☐ Patient has prior diagnosis of corneal dystrophy

  Medical Note: _____
- ☐ Patient has a family history of eye diseases or corneal dystrophies

  Medical Note: _____
- ☐ To determine whether corneal opacities observed on exam are dystrophic or due to another cause.

  Medical Note: _____
- ☐ Other diagnostic or medical reason not noted above

  Medical Note: _____

TEST APPLICATION

The test results will be utilized by me to:

Note: check all that apply

- ☐ Differentiate between dystrophic and non-dystrophic corneal opacities
- ☐ Determine the appropriate means of managing the corneal opacities
- ☐ Identify individuals at risk of exacerbation of a *TGFBI* dystrophy following a keratorefractive procedure
- ☐ Determine the appropriate frequency of monitoring the corneal opacities for progression
- ☐ Recommend life style changes to minimize condition exacerbation
- ☐ Determine whether genetic testing should be offered to family members
- ☐ Provide a definitive diagnosis to encourage patient compliance with the recommended treatment regimen
- ☐ Others, specify _____

I certify that the testing reference above is medically necessary. I intended to utilize the best results to inform my treatment decision as indicated to the application section above.

Physician Signature: _____ Date: _____

Physician print name: _____

Clinic Name: _____