Maine Center for Disease Control and Prevention
An Office of the Department of Health and Human Services

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| **To:** | | **From:** | Trisha Donnarumma, Patient Navigator<br>Maine CDC Breast and Cervical Health Program |
| **Fax:** | | **Phone:** | 207-287-5057 /// FAX: 207-287-2279 |
| **Date:** | | **Page(s):** | 1 |
| **RE:** | ***MBCHP Coverage for Breast MRI – Program Pre-Approval Required*** | | |

To MBCHP Provider:

It is standard practice to determine if a woman is at high risk or average risk for breast cancer in order for her to make an informed decision about screening and to receive the appropriate screening tests. Woman assessed to be at high risk for breast cancer are recommended to have an annual mammogram plus a Breast MRI.

As of 01/01/2019, MBCHP will approve coverage for a Breast MRI (when used in conjunction with an annual mammogram) to evaluate clients who are assessed to be at high risk for breast cancer, and/or to assess areas of concern on a mammogram.

***Reason for procedure, requested documentation and Provider signature must be completed and faxed to 207-287-2279 before MBCHP can approve coverage for Breast MRI.***

***Note:*** Breast MRI done alone as a breast cancer screening tool will not be covered;
Breast MRI to assess the extent of disease in a woman who has just been diagnosed with breast cancer will not be covered.

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**MBCHP CLIENT'S NAME:** _____

**MBCHP CLIENT'S DOB:** _____ / _____ /_____

Check reason for recommending Breast MRI:

☐ Client is a known carrier of a BRCA1 / BRCA2 gene mutation.

☐ Client has not been tested but has first-degree relative(s) (parent, brother, sister, or child) with known BRCA1 / BRCA2 gene mutation.

☐ Client has a lifetime breast cancer risk of ≥20% as estimated and documented with a validated risk assessment model (such as the BRCAPRO, Gail, Tyrer-Cuzick or similar models).
- Name of Risk Assessment Model used: _____

☐ Client was treated with radiation to the chest wall between age 10 and 30 years (e.g., for the treatment of Hodgkin's disease).

☐ Client, or first-degree relative, has Li-Fraumeni syndrome or similar genetic syndrome.

☐ Client with prior history of breast cancer. Client must have completed treatment and no longer qualifies for the Maine Treatment Act.

☐ Client has mammographic finding that requires better assessment of an area of concern: please include radiology report.

**Breast MRI scheduled date: _____ / _____ / _____ Facility: _____**

**Physician's Signature:** _____ **Date:** _____/ _____/ _____

***Upon completion, a copy of Breast MRI report must be submitted to MBCHP.***