Breast & Cervical CANCER EARLY DETECTION Program of Alabama

MRI FORM Instructions/Guidance

1. **ALL MRIs MUST HAVE PRIOR AUTHORIZATION AND BE SIGNED** by the Alabama Breast and Cervical Cancer Early Detection Program (ABCCEDP) Regional Coordinator.

2. ABCCEDP will reimburse a screening breast MRI for high-risk women with one of the following:

   - Genetic mutation such as BRCA 1 or 2 **(Must have documentation of genetic mutation)**
   - First degree relative (mother, sister, daughter) with a genetic mutation such as BRCA 1 or 2 **(Must have documentation of breast cancer and/or genetic mutation)**
   - History of radiation treatment to the chest area before the age of 30 (**typically for Hodgkin's Lymphoma)**
   - Personal history of lobular carcinoma in situ **(Must have documentation of lobular carcinoma in situ)**
   - Patient has unusual circumstances that need to be approved by the Medical Advisory Board **(Must supply adequate reports for review by the Medical Advisory Committee)**

   ***Any of the above reasons constitutes a >20% breast risk assessment score which is considered high risk.**

3. MRIs should **NEVER** be done alone as a breast cancer screening tool. A screening MRI will be reimbursed for high-risk women 6 months after a negative/benign mammogram. The ABCCEDP Program will only reimburse a screening MRI for high-risk women once a year.

4. The ABCCEDP only covers screening MRIs, not diagnostic MRIs.

5. Breast MRIs cannot be reimbursed to assess the extent of disease in clients who have already been diagnosed with breast cancer.

6. To be most effective, it is critical to complete MRIs at facilities equipped with breast MRI equipment and perform MRI guided biopsies.

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BREAST MRI AUTHORIZATION & RESULTS FORM

TRACKING NUMBER REQUIRED

PATIENT INFORMATION (to be completed by the primary provider or breast surgeon's office)

Patient Name (Last Name, First Name) _____

Date of Birth (MM/DD/YYYY) _____ **Social Security Number XXX-XX-**_____ **Patient Telephone** _____

Provider Name (Breast Surgeon/Primary Care Provider) _____ **Date of Referral** _____

Name of the Referral Hospital _____ **Provider Phone** _____

1. INDICATIONS FOR ORDERING MRI (to be completed by the primary provider/breast surgeon's office)

Please check all that apply:

☐ I. Patient has genetic mutation such as BRCA 1 or 2 (Must have documentation of genetic mutation)

☐ II. Patient has a 1st degree relative (mother, sister, daughter) with a known genetic mutation such as BRCA 1 or BRCA 2 (Must have documentation of genetic mutation)

☐ III. History of radiation treatment to the chest area before the age of 30

☐ IV. Personal history of lobular carcinoma in situ (Must have documentation of lobular carcinoma in situ)

☐ V. Patient has findings/risk factors that the provider deems necessary for further consideration from the Medical Advisory Committee (Must supply adequate reports for review by the Medical Advisory Committee)

*Any of the above reasons constitutes a >20% breast risk assessment score which is considered high risk.
(e.g. www.cancer.gov/bcrisktool/ or https://ibis-risk-calculator.magview.com/)

2. MRI ORDER

Ordering Provider: _____

Facility/Provider Contact Number: _____

Facility Name or County Health Department Address:

_____

_____

3. AUTHORIZATION FROM ABCCEDP REGIONAL COORDINATOR

Signature of Regional Coordinator: _____

Date of MRI: _____Provider Signature: _____

4. MRI RESULTS (Attach a copy of the results, completed by MRI provider)

☐ 1. Negative (BI-RADS 1)

☐ 2. Benign Finding (BI-RADS 2)

☐ 3. Probably Benign (BI-RADS 3)

☐ 4. Suspicious (BI-RADS 4)

☐ 5. Highly Suggestive of Malignancy (BI-RADS 5)

☐ 6. Known Malignancy (BI-RADS 6)

☐ 7. Incomplete: Need Additional Imaging for Evaluation (BI-RADS 0)

☐ 8. Results Pending

☐ 9. Not Done