TO: All Health Insurers and Health Care Centers Authorized To Conduct Business In Connecticut

RE: Revised Pre-Authorization Form for Cancer Clinical Trials

This is a reminder to all health insurers and health care centers operating in Connecticut that pursuant to sections 38a-504f and 38a-542f of the Connecticut General Statutes, and section 38a-504a-3 of the Regulations of the Connecticut State Agencies, all requests for coverage of routine patient care costs for individuals enrolled in Phase I, II and III cancer clinical trials must be pre-authorized through a submission of a completed, standardized form that all providers, hospitals and institutions shall submit when seeking to enroll an insured person in the cancer clinical trial. The Connecticut Insurance Department ("Department") wants to make sure that the form is properly required and used to enable proper identification of cancer clinical trial participants and proper data collection related to benefits provided under the cancer clinical trial mandates.

Working with representatives of the Connecticut Association of Health Plans, medical directors and counsel of licensed health care centers, the Attorney General's Office and clinical trial staff of the Neag Comprehensive Cancer Center of the University of Connecticut, the Department undertook a review of the cancer clinical trial pre-authorization form to update it. As a result of that review, the form has been revised and a copy of the revised form is attached for your information. A copy of the form is also available on the Department's website under "Forms".

Please contact the Insurance Department Life & Health Division at cid.lh@ct.gov with any questions.
Request For Authorization for Coverage of Routine Patient Care Costs Associated with Cancer Clinical Trials

Section I

Date: ______________________________

Member name: ________________________________________________________________

Member ID #: _________________________________________________________________

Member Date of Birth: ____________________________________________________________

Health Insurer: _________________________________________________________________

Treating Physician: ______________________________________________________________

Contact Person for Additional Information Regarding Member’s Treatment:

Name: ______________________________________________________________________

Address: _____________________________________________________________________

Phone number: __________________________________________________________________

Fax number: ___________________________________________________________________

E-mail address: __________________________________________________________________

Service requested is: ___ Outpatient   ___ Inpatient   ___ Office Setting

If outpatient or inpatient is checked:
Facility name & address: ______________________________________________________________________
____________________________________________________________________

Please Note: Pursuant to Connecticut General Statutes Sections 38a-504a et seq. (individual coverage) or 38a-542a et seq. (group coverage), you may be asked to provide additional information about the cancer clinical trial or the member’s diagnosis and condition prior to the authorization of this request.
Member name: __________________________ Member ID#: ________________

Section II

Diagnosis code: ________________ Stage __________________________

Clinical trial phase: _____ I _____ II _____ III

Clinical trial sponsor: __________________________

Please identify the funding source for the trial? (federal government, private entity, charitable organization – please provide specific entity name) __________________________

Clinical Trial has been reviewed and approved by: (must check one per Conn. Gen. Stat. Sec. 38a-504b or 38a-542)

___ National Institute of Health
___ National Cancer Institute
___ Federal Food and Drug Administration
___ Federal Dept. of Defense
___ Federal Dept. of Veterans Affairs

Check one: ____ Single center study  ____ Multiple center study

List name(s) and address(es) of center(s):

________________________________________________________________________

Information regarding the proposed trial: (if additional space is needed for any of the following questions, please attach separate sheet)

1. Please state the anticipated therapeutic effect ________________________________________________________________

________________________________________________________________________

2. How does the protocol differ from the standard treatment for this diagnosis?

________________________________________________________________________

________________________________________________________________________

3. Please provide a list of tests, procedures, drugs, equipment and other services to be covered by the trial.

________________________________________________________________________

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________________________________________________________________________

4. Please attach copies of the study calendar and schema page from the clinical trial proposal.