STATE OF CONNECTICUT

INSURANCE DEPARTMENT

BULLETIN HC - 79

June 17, 2010

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

RE: Revised Pre-Authorization Form for Cancer Clinical Trials

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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.govwith any questions.

Thomas R. Sullivan
Insurance Commissioner

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.
_____
_____
_____

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