Clinical trials prior authorization form

Clinical trials aren't covered for Priority Health Medicaid. For self-funded groups, verify clinical trial coverage with the individual plan document

☐ Check if your facility is participating as an in-network provider for Cigna

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Date: _____

Member information

Last name		First name			
Priority Health ID#		Date of birth			
Primary care physician		PCP phone		PCP fax	

Provider information

Provider		Tax ID – *required*	
Address		Phone	
		Fax	
Contact first & last name			

Facility information

Facility		Tax ID – *required*	
Address		Phone	
		Fax	
Contact first & last name			

Clinical information

Diagnosis code(s)		Procedure code(s)	
Brief description of trial – *attach copy of trial protocol*			
Trial sponsor and funding source			
NCT or clinical trial number			

Form continues on the next page

Coverage verification

Coverage for routine patient care costs in clinical trial may be a covered benefit with all of the following are met (check all that apply):

1	Member is eligible to participate in an approved clinical trial for treatment of one of the following: ☐ Cancer ☐ Other life-threatening disease / condition defined as: terminal illness or a chronic, life-threatening, severely disabling disease that is causing serious clinical deterioration
2	☐ Member or referring healthcare provider provides medical and scientific information establishing that participation in trial would be appropriate based on the conditions described in (1) above.
3	Approved clinical trial is a ☐ Phase 1, ☐ Phase 2, ☐ Phase 3, ☐ Phase IV clinical trial conducted in relation to the prevention, detection or treatment of cancer or life-threatening disease or condition, and meets one of the following (A, B or C): ☐ A. Federally funded trials approved or funded by one or more of the following (check all that apply): ☐ i. The National Institutes of Health ☐ ii. The Centers for Disease Control and Prevention ☐ iii. The Agency for Health Care Research and Quality ☐ iv. The Center for Medicare and Medicaid Services ☐ v. Cooperative group or center of any of the entities described in clauses in (i) through (iv) or the Department of Defense or the Department of Veterans Affairs ☐ vi. Qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center-support grants ☐ vii. The Department of Veterans Affairs; The Department of Defense; The Department of Energy when conditions described in the medical policy are met. ☐ ClinicalTrials.gov identifier: _____ ☐ B. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration. Include INDA number here: _____ ☐ C. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
4	☐ An advance care planning assessment has been completed by a qualified provider for members with Stage IV cancer or other life-threatening condition.

Include the following documentation with this request:

- ☐ Documentation showing this is a CMS or other National Government Service (NGS) approved trial
- ☐ Completed advanced care planning assessment – *if applicable*
- ☐ Copy of informed consent agreement to participate in clinical trial

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