Medical Management Unit

AHCCCS/DMCS

801 East Jefferson, MD-6100

Phoenix, AZ.  85034

FAX: (602) 252 - 2180

Date: (insert date)

Request for Catastrophic Reinsurance

RE: (insert member name)

AHCCCS ID: (insert AHCCCS ID)

DOB: (insert member’s DOB)

The Health Plan Medical Director has reviewed the medical documentation for this member and is requesting catastrophic reinsurance. The member qualifies for the following type of catastrophic reinsurance:

​​​ Gaucher’s Disease Type 1

​​Von Willebrand’s Disease, reinsurance eligibility is based on the following: ​Choose an item.

​​Hemophilia

​​CAR-T Choose an item. .​ and indicate the diagnosis: (**Records not required**)

**Diagnosis**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

​​Biologicals/High-Cost Specialty Drugs Choose an item.​ indicate the diagnosis:

**Diagnosis**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

​​This member has been newly identified as meeting criteria for Catastrophic Reinsurance. Attached you will find the supporting documentation.

​This member is currently eligible for Catastrophic Reinsurance.  I will not be attaching any additional information unless requested by AHCCCS.

​​This member has previously been receiving Catastrophic Reinsurance.  This is notification of contractor change on (**Insert date**) from (**Insert previous contractor name**) to (**Insert new contractor name**).

Indicate the following if this is a second biologic/high-cost drug:

​​The previous medication (**Insert drug name**) was discontinued on (**Insert date**).

​​This medication will be used simultaneously with the previously reinsured medication (**Insert drug name**).  Attached you will find the supporting clinical documentation for this member.

Sincerely,

Medical Director

Health Plan