Medical Management Unit

Division of Health Care Services

AHCCCS

701 East Jefferson

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)

MEMBER HAS MEDICARE INSURANCE: YES OR NO

IF YES, PLEASE PROVIDE MEDICARE ID:

The Health Plan Medical Director has reviewed the medical documentation for this member and is submitting this member for 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:

* Type 1 and Type 2A which is non-responsive to Desmopressin (DDAVP)
* Type 2B, Type 2M, and Type 2N are eligible based on the diagnoses only
* Type 3 is eligible based on the diagnosis only

 \_\_\_\_ Hemophilia

 \_\_\_\_ High-Cost Biologics and Specialty Drugs-please check the drug requested for

 reinsurance below:

|  |  |  |  |
| --- | --- | --- | --- |
| \_\_\_ Acthar Gel   | \_\_\_ Gamifant   | \_\_\_ Novoseven   | \_\_\_ Soliris   |
| \_\_\_Aldurazyme   | \_\_\_ Gattex   | \_\_\_ Orfadin   | \_\_\_ Spinraza   |
| \_\_\_ Amondys 45  | \_\_\_ Haegarda   | \_\_\_ Orkambi   | \_\_\_ Symdeko   |
| \_\_\_Amuvuttra   |  \_\_\_ Icatibant   | \_\_\_ Orladeyo   | \_\_\_ Syprine   |
| \_\_\_ Ceprotin   | \_\_\_ Juxtapid  | \_\_\_ Oxlumo   | \_\_\_ Takhzyro   |
| \_\_\_ Cinryze   | \_\_\_ Kalbitor   | \_\_\_ Procysbi   | \_\_\_ Trikafta   |
| \_\_\_ Elaprase   | \_\_\_ Kalydeco   | \_\_\_ Ravicti   | \_\_\_ Ultomiris   |
| \_\_\_ Evrysdi   | \_\_\_ Kanuma   | \_\_\_ Revcovi   | \_\_\_ Viltepso   |
| \_\_\_ Exondys   | \_\_\_ Kuvan   | \_\_\_ Ruconest   | \_\_\_Vyjuvek   |
| \_\_\_ Fabryzyme   | \_\_\_ Kynamro   | \_\_\_Skyclarys   | \_\_\_ Vyondys   |
| \_\_\_ Firazyr   | \_\_\_ Lumizyme   | \_\_\_Skysona   | \_\_\_ Zolgensma   |
| \_\_\_ Firdapse   | \_\_\_ Luxturna   | \_\_\_Sohonos   | \_\_\_Zynteglo   |
| \_\_\_ Galafold   | \_\_\_ Myozyme   |   |    |
|   |   |   |    |
|   |   |   |   |

 \_\_\_\_ This member has been identified as meeting criteria for Catastrophic Reinsurance and has not been receiving Catastrophic Reinsurance. Attached you will find the supporting clinical documentation for this member.

 \_\_\_\_ This member is currently eligible for Catastrophic Reinsurance. I will not be attaching any additional information unless AHCCCS requests it.

 \_\_\_\_ 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).

Please 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