Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Keveyis® (dichlorphenamide)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product: ☐ Keveyis 50 mg tablet

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Drug cost information

The wholesale acquisition cost for each Keveyis tablet is $136.50. The cost of treatment with this drug may be more than $196,500 each year.

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Must have diagnosis of primary hyperkalemic periodic paralysis, primary hypokalemic periodic paralysis, and related variants
2. Diagnosis confirmed by ONE of the following: Genetic testing, established family history, provocative testing, or electromyography
3. Baseline and periodic monitoring of serum potassium and bicarbonate levels
4. Documentation that lifestyle modifications, dietary restrictions and exercise restrictions have been maximally challenged
5. Inadequate response, intolerance, or contraindication to acetazolamide

Continuation criteria, must meet the following (initial approval will be for 2 months):

1. Must continue to meet all of the initial requirements
2. Documentation that the patient has had a reduction in the number of paralytic attacks

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

All fields must be complete and legible for review. Your office will receive a response via fax.

New 11/2015
Last reviewed 11/2018

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ ***hyper***kalemic periodic paralysis
- ☐ ***hypo***kalemic periodic paralysis
- ☐ *Other – the patient's condition is:* _____

Rationale for use: _____

B. Please fax supporting documentation of diagnosis as required (genetic testing, established family history of primary hyper/hypo periodic paralysis, provocative testing, or electromyography).

C. Please provide documentation that lifestyle modifications, dietary restrictions, and exercise restrictions have been followed and are not effective.

D. Has the patient tried acetazolamide?

- ☐ Yes, Dates, dose and response: _____
- ☐ No, rationale: _____

Additional information: When approved dose is limited to 120 tablets per 30 days (4 per day).

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New 11/2015
Last reviewed 11/2018