Keveyis (dichlorphenamide)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

Continued on next page.

© 2017–2024 Prime Therapeutics Management LLC, a Prime Therapeutics LLC company

Keveyis (dichlorphenamide)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Primary hyperkalemic peridioc paralysis ☐ Primary hypokalemic peridioc paralysis ☐ Other diagnosis: _____ICD-10_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:

Is the medication being prescribed by or in consultation with a neurologist? ☐ Yes ☐ No

Has the patient tried and had an inadequate response to treatment with acetazolamide at a dose of 125-1500 mg/day? ☐ Yes ☐ No
Please provide supporting documentation, including the dose and trial dates.

Does the patient have a lack of respnse, contraindication or intolerance to treatment with acetazolamide?
☐ Yes ☐ No *Please submit documentation.*

If diagnosis is for hyperkalemic periodic paralysis, also answer the following:

Was the diagnosis confirmed by ONE of the following?*

☐ Genetic testing

☐ Provocative testing

☐ Electromyography *please provide supporting documentation

If diagnosis is for hypokalemic periodic paralysis, also answer the following:

Is patient's serum potassium level less than 3.5mmol/L during an attack? ☐ Yes ☐ No
please provide supporting documentation

Does patient have a normal TSH level? ☐ Yes ☐ No *please provide supporting documentation*

Does patient have a normal free thyroxine(FT4) level? ☐ Yes ☐ No *please provide supporting documentation

Does patient have a normal free triiodothyronine(FT3) level? ☐ Yes ☐ No *please provide supporting documentation*

Does the patient have renal potassium wasting? ☐ Yes ☐ No

© 2017–2024 Prime Therapeutics Management LLC, a Prime Therapeutics LLC company

If no, please provide one of the following documentations:

□ **Urinary potassium/creatinine ratio (=2.5 or below) during an attack*** ***please provide supporting documentation***
OR

□ **Transtubular potassium concentration gradient(TTKG, or [urinary potassium/plasma potassium]/[urine osmolality/blood osmolality]) equaling 3.0 or below during an attack *** ***please provide supporting documentation***

Was the diagnosis confirmed by ONE of the following? ***please provide supporting documentation***

□ **Genetic testing identifying a pathogenic variant in *CACNA1S* or *SCN4A* *OR***

□ **Electromyography during an interictal period showing absence of myotonic discharges AND a progressive and marked decrease in the amplitude of compound motor action potentials(CMAP) during long exercise test**
***please provide supporting documentation**

Renewal Therapy:
You must answer ALL of the following questions

Has the patient had a positive clinical response to Keveyis therapy such as a reduced frequency and/or severity of attacks/episodes? □ **Yes** □ **No**

Is the medication being prescribed by or in consultation with a neurologist? □ **Yes** □ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP - 4201
P.O. Box 64811
St. Paul, MN 55164-0811

© 2017–2024 Prime Therapeutics Management LLC, a Prime Therapeutics LLC company