OPTIMA HEALTH PLAN

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-800-750-9692.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization may be delayed.**

Drug Requested: Keveyis® (dichlorphenamide)

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Recommended Dosage: Oral: Initial: 50 mg once or twice daily; may increase or decrease dosage at weekly intervals (or more frequently in response to adverse reactions); minimum: 50 mg/day; maximum: 200 mg/day. Evaluate response and need for continued therapy after 2 months of treatment

Quantity Limit: 120 tablets per 30 days

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 12 months

- ❑ Member is 18 years of age or older
- ❑ Prescribed by or in consultation with a neurologist or a physician who specializes in the care of individuals with primary periodic paralysis (e.g., muscle disease specialist, physiatrist)
- ❑ Member has a diagnosis of primary periodic paralysis confirmed by **BOTH** of the following:
  - ❑ Genetic testing for confirmation of SCN4 or CACNA1S mutation
  - ❑ Electromyography confirming absence of myotonic discharges
- ❑ Provider has submitted lab or chart note confirmation to support **ONE** of the following:
  - ❑ If diagnosis is hypokalemic periodic paralysis: Serum K < 3.5 mEq/L during attack OR family history of condition
  - ❑ If diagnosis is hyperkalemic periodic paralysis: Serum K > 5.0 mEq/L during attack OR increased serum K >1.5 mEq/L during attack OR family history of condition
- ❑ Member has had an inadequate response to a trial of acetazolamide at a dose of 125-1500 mg/day for at least 60 days within a year of request **OR** has a documented contraindication to acetazolamide **(verified by chart notes or pharmacy paid claims; inadequate response is defined as no reduction in number of attacks per month after receiving treatment with acetazolamide at recommended doses)**
- ❑ Provider has submitted chart notes documenting member's baseline number of attacks per month prior to acetazolamide therapy: _____

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- ❑ Baseline values for frequency and severity of attacks of muscle weakness experienced after beginning acetazolamide therapy has been submitted **(necessary for renewal)**: _____
- ❑ Member continues to have paralytic attacks despite dietary intervention and avoidance of trigger

Reauthorization: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member has experienced disease response as indicated by a decrease in the frequency and/or severity of attacks of muscle weakness from pre-treatment baseline
- ❑ Member has **NOT** experienced unacceptable toxicity from the drug (e.g., hypersensitivity reactions, hypokalemia, metabolic acidosis, falls)

Medication being provided by Specialty Pharmacy - PropriumRx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

Member Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by Pharmacy and Therapeutics Committee**: 7/21/2022
REVISED/UPDATED: 8/10/2022