UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for Keveyis

Program	Prior Authorization
Medication	Keveyis (dichlorphenamide)
Markets in Scope	Arizona, California, Florida-CHIP, Hawaii, Maryland, Nevada, New Mexico, New York, New York EPP, Ohio, Rhode Island, Washington, New Jersey, Louisiana
Issue Date	12/2015
Pharmacy and Therapeutics Approval Date	2/2018
Effective Date	4/2018

1. Background:

Keveyis is indicated for the treatment of primary hyperkalemic periodic paralysis, primary hypokalemic periodic paralysis, and related variants.[1] These are autosomal dominant inherited channelopathies that manifest as abnormal, often potassium sensitive, muscle membrane excitability leading to episodic flaccid paralysis. The precise mechanism by which Keveyis exerts its therapeutic effects in patients with periodic paralysis is not known.[2]

2. Coverage Criteria:

A. Initial Authorization

1. Diagnosis of **one** of the following:

   a. Diagnosis of primary hyperkalemic periodic paralysis or related variant

   -OR-

   b. Diagnosis of primary hypokalemic periodic paralysis or related variant

Authorization will be issued for 12 months.

B. Reauthorization

1. Documentation of positive clinical response to Keveyis therapy

Authorization will be issued for 12 months.

3. References:

1. Keveyis™ Prescribing Information. Taro Pharmaceuticals U.S.A., Inc., Hawthorne, NY. August 2015.
2. The primary periodic paralyses: diagnosis, pathogenesis and treatment. S. L. Venance, S. C. Cannon, D. Fialho, et al. Brain Jan 2006, 129 (1) 8-17; DOI: 10.1093/brain/awh639.

Program	Prior Authorization - Keveyis (dichlorphenamide)
Change Control	
Date	Change
12/2015	New policy
11/2016	Annual review, updated policy template
2/2017	Annual review, no changes to clinical criteria.
3/2017	Changed initial authorization to 12 months
2/2018	Updated background, criteria, and references to align with Employer and Individual's notification policy.