PRIOR AUTHORIZATION REQUEST
Keveyis

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

Medication Requested:_____ Qty Requested: _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. What is the indication or diagnosis?
   - ☐ Hypokalemic periodic paralysis (HypoPP) and related variants – **Please proceed to question 2**
   - ☐ Hyperkalemic periodic paralysis (HyperPP) and related variants – **Please proceed to question 2**
   - ☐ Other indications or diagnoses – Please specify _____
2. Is the request for initial therapy or continuation of therapy?
   - ☐ Initial therapy – **Please answer questions 3 – 10, 12 - 15**
   - ☐ Continuation of therapy – Please answer question 11
3. ☐ Yes ☐ No Has the patient had a serum potassium concentration of less than 3.5 mEq/L during a paralytic attack?
4. ☐ Yes ☐ No Does the patient have a family history of the condition?
5. ☐ Yes ☐ No Does the patient have a genetically confirmed skeletal muscle calcium or sodium channel mutation?
6. ☐ Yes ☐ No Has the prescriber excluded other reasons for acquired hypokalemia (e.g., renal, adrenal, thyroid dysfunction; renal tubular acidosis; diuretic or laxative abuse)?
7. ☐ Yes ☐ No Has the patient had improvements in paralysis attack symptoms with potassium intake?
8. ☐ Yes ☐ No Has the patient tried oral acetazolamide therapy (for example, Diamox tablets, Diamox Sequels extended-release capsules, generics)?
9. ☐ Yes ☐ No According to the prescriber, did acetazolamide therapy worsen the paralytic attack frequency or severity in the patient?
10. ☐ Yes ☐ No Is the requested medication prescribed by or in consultation with a neurologist or a physician who specializes in the care of patients with primary periodic paralysis (for example, muscle disease specialist, physiatrist)?
11. ☐ Yes ☐ No Has the patient responded to Keveyis (for example, decrease in the frequency or severity of paralytic attacks) as determined by the prescriber?

If you have any questions, call: 800-753-2851

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12.	☐ Yes ☐ No	Has the patient had an increase from baseline in serum potassium concentration of greater than or equal to 1.5 mEq/L during a paralytic attack?
13.	☐ Yes ☐ No	Has the patient had a serum potassium concentration during a paralytic attack of greater than 5.0 mEq/L?
14.	☐ Yes ☐ No	Does the patient have a genetically confirmed skeletal muscle sodium channel mutation?
15.	☐ Yes ☐ No	Has the prescriber excluded other reasons for acquired hyperkalemia (for example, drug abuse, renal and adrenal dysfunction)?

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior

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