PRIOR AUTHORIZATION REQUEST

Keveyis/Ormalvi/Dichlorphenamide

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests.

1 What is the indication or diagnosis?
[] Hypokalemic periodic paralysis (HypoPP) and related variants (If checked, go to 2)

[] Hyperkalemic periodic paralysis (HyperPP) and related variants (If checked, go to 12)

[] Other (If checked, no further questions)

2 Is the request for initial therapy or continuation of therapy?
[] Initial therapy (If checked, go to 3)

If you have any questions, call: 1-888-258-8250

PRIOR AUTHORIZATION REQUEST

	[] Continuation of therapy (If checked, go to 11)		
3	Has the patient had a serum potassium concentration of less than 3.5 mEq/L during a paralytic attack? [If yes, skip to question 7.]	Yes	No
4	Does the patient have a family history of the condition? [If yes, skip to question 7.]	Yes	No
5	Does the patient have a genetically confirmed skeletal muscle calcium or sodium channel mutation? [If no, no further questions.]	Yes	No
6	Has the prescriber excluded other reasons for acquired hypokalemia (e.g., renal, adrenal, thyroid dysfunction; renal tubular acidosis; diuretic or laxative abuse)? [If no, no further questions.]	Yes	No
7	Has the patient had improvements in paralysis attack symptoms with potassium intake? [If no, no further questions.]	Yes	No
8	Has the patient tried oral acetazolamide therapy (for example, Diamox tablets, Diamox Sequels extended-release capsules, generics)? [If no, no further questions.]	Yes	No
9	According to the prescriber, did acetazolamide therapy worsen the paralytic attack frequency or severity in the patient? [If yes, no further questions.]	Yes	No
10	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)? [No further questions.]	Yes	No
11	Has the patient responded to the requested medication (for example, decrease in the frequency or severity of paralytic attacks) as determined by the prescriber? [No further questions.]	Yes	No
12	Is the request for initial therapy or continuation of therapy? [] Initial therapy (If checked, go to 13) [] Continuation of therapy (If checked, go to 21)		
13	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? [If yes, skip to question 17.]	Yes	No
14	Has the patient had a serum potassium concentration during a paralytic attack of	Yes	No

PRIOR AUTHORIZATION REQUEST

	greater than 5.0 mEq/L? [If yes, skip to question 17.]		
15	Does the patient have a family history of the condition? [If yes, skip to question 17.]	Yes	No
16	Does the patient have a genetically confirmed skeletal muscle sodium channel mutation? [If no, no further questions.]	Yes	No
17	Has the prescriber excluded other reasons for acquired hyperkalemia (for example, drug abuse, renal and adrenal dysfunction)? [If no, no further questions.]	Yes	No
18	Has the patient tried oral acetazolamide therapy (for example, Diamox tablets, Diamox Sequels extended-release capsules, generics)? [If no, no further questions.]	Yes	No
19	According to the prescriber, did acetazolamide therapy worsen the paralytic attack frequency or severity in the patient? [If yes, no further questions.]	Yes	No
20	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)? [No further questions.]	Yes	No
21	Has the patient responded to the requested medication (for example, decrease in the frequency or severity of paralytic attacks) as determined by the prescriber?	Yes	No

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: 1-833-896-0656

If you have any questions, call: 1-888-258-8250

PRIOR AUTHORIZATION REQUEST

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 authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

If you have any questions, call:
1-888-258-8250