



# 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: [HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI\\_DISCLOSURE\\_AUTHORIZATION.PDF](https://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF)

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:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.





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MEMBER'S LAST NAME: \_\_\_\_\_ MEMBER'S FIRST NAME: \_\_\_\_\_

<b>1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION?</b> <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
<b>MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):</b>  	<b>DURATION OF THERAPY (SPECIFY DATES):</b>  	<b>RESPONSE/REASON FOR FAILURE/ALLERGY:</b>  
<b>2. LIST DIAGNOSES:</b> <input type="checkbox"/> Primary hyperkalemic peridioc paralysis <input type="checkbox"/> Primary hypokalemic peridioc paralysis <input type="checkbox"/> Other diagnosis: _____ ICD-10 _____		<b>ICD-10:</b>  
<b>3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.</b>		
<b>Clinical Information:</b>  <b>Is the medication being prescribed by or in consultation with a neurologist?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>Has the patient tried and had an inadequate response to treatment with acetazolamide at a dose of 125-1500 mg/day?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please provide supporting documentation, including the dose and trial dates.</i>  <b>Does the patient have a lack of respnse, contraindication or intolerance to treatment with acetazolamide?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation.</i>		
<b>If diagnosis is for hyperkalemic periodic paralysis, also answer the following:</b>  <b>Was the diagnosis confirmed by ONE of the following?*</b> <input type="checkbox"/> Genetic testing <input type="checkbox"/> Provocative testing <input type="checkbox"/> Electromyography *please provide supporting documentation		
<b>If diagnosis is for hypokalemic periodic paralysis, also answer the following:</b>  <b>Is patient's serum potassium level less than 3.5mmol/L during an attack?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*please provide supporting documentation</i>  <b>Does patient have a normal TSH level?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*please provide supporting documentation</i>  <b>Does patient have a normal free thyroxine(FT4) level?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*please provide supporting documentation</i>  <b>Does patient have a normal free triiodothyronine(FT3) level?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*please provide supporting documentation</i>  <b>Does the patient have renal potassium wasting?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		





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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:** Magellan Rx Management Prior Authorization Program

Attn: CP - 4201

P.O. Box 64811

St. Paul, MN 55164-0811

