Prior Authorization Request Form for
dichlorphenamide **(Keveyis)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for Keveyis*	☐ Yes Proceed to question **2**	☐ No Proceed to question **4**
2. Does the patient have a diagnosis of hypokalemic periodic paralysis (HypoPP) or hyperkalemic periodic paralysis (HyperPP) or related variant?	☐ Yes Proceed to question **3**	☐ No **STOP** Coverage not approved
3. Has the patient responded to therapy with the requested medication (for example: decrease in the frequency or severity of paralytic attacks) as determined by the prescriber physician?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved
4. Does the patient have a diagnosis of primary hypokalemic periodic paralysis (HypoPP) or primary hyperkalemic periodic paralysis (HyperPP)?	☐ Primary hypokalemic periodic paralysis (HypoPP) or related variant - Proceed to question **5** ☐ Primary hyperkalemic periodic paralysis (HyperPP) or related variant – Proceed to question **6** ☐ All other indications or diagnoses – **STOP -** Coverage not approved	
5. Has the patient had a serum potassium concentration of less than 3.5 mEq/L during a paralytic attack?	☐ Yes Proceed to question **9**	☐ No Proceed to question **7**
6. 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 OR has the patient had a serum potassium concentration during a paralytic attach of greater than 5 mEq/L?	☐ Yes Proceed to question **10**	☐ No Proceed to question **7**

7. Does the patient have a family history of hypokalemic periodic paralysis (HypoPP) or hyperkalemic periodic paralysis (HyperPP)?	☐ Yes Proceed to question **9**	☐ No Proceed to question **8**
8. Does the patient have a genetically confirmed skeletal muscle calcium or sodium channel mutation?	☐ Yes Proceed to question **9**	☐ No **STOP** Coverage not approved
9. Has the patient had an improvement in paralysis attack symptoms with potassium intake?	☐ Yes Proceed to question **10**	☐ No **STOP** Coverage not approved
10. Has the patient tried and failed oral acetazolamide therapy (for example Diamox tablets or Diamox Sequels ER caps)?	☐ Yes Proceed to question **11**	☐ No **STOP** Coverage not approved
11. Has acetazolamide therapy worsened the paralytic attack frequency or severity in the patient according to the prescribing physician?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **12**
12. Is the requested medication being 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 or Physical Medicine and Rehab [PMNR])?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[31 July 2019]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: