UnitedHealthcare®

Clinical Pharmacy Program Guidelines for Keveyis

Program	Prior Authorization
Medication	Keveyis (Dichlorphenamide)

1. **Background:**

Drugs Requiring Prior Authorization:

KEVEYIS 50 MG TABLET

Coverage Criteria:

1. Patient is greater than or equal to (≥) 18 years of age

-AND-

2. Patient has a diagnosis of diagnosis of primary periodic paralysis in the last 730 days

-AND-

3. Patient has a claim for acetazolamide in the last 365 days

-AND-

4. The requested dose is less than or equal to (≤) 4 units per day

Approve for 365 Days

Clinical Criteria Supporting Tables:

Criteria 2 (diagnosis of primary periodic paralysis) Required diagnoses: 1 Look back timeframe: 730 days	
ICD-10 Code	**Description**
G723	PERIODIC PARALYSIS

Criteria 3 (acetazolamide) Required number of claims: 1 Look back timeframe: 365 days
Label Name
ACETAZOLAMIDE 125 MG TABLET
ACETAZOLAMIDE 250 MG TABLET
ACETAZOLAMIDE ER 500 MG CAP
DIAMOX SEQUELS ER 500 MG CAP

Program	Program Type - Prior Authorization
Change Control	
Date	Change
7/1/18	New Program
4/8/2020	1. Updated minor formatting and gramattical errors. 2. Change criteria 3 from 730 days to 365 days. 3. Added Clinical Criteria Supporting Tables.