



## Keveyis [dichlorphenamide]

### Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506**. For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to [do\\_not\\_call@cvscaremark.com](mailto:do_not_call@cvscaremark.com). An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

<b>Patient's Name:</b> _____	<b>Date:</b> _____
<b>Patient's ID:</b> _____	<b>Patient's Date of Birth:</b> _____
<b>Physician's Name:</b> _____	
<b>Specialty:</b> _____	<b>NPI#:</b> _____
<b>Physician Office Telephone:</b> _____	<b>Physician Office Fax:</b> _____
<b>Request Initiated For:</b> _____	

- What is the diagnosis?
  - Primary hypokalemic periodic paralysis
  - Primary hyperkalemic periodic paralysis
  - Other \_\_\_\_\_
- What is the ICD-10 code? \_\_\_\_\_
- Is the request for a continuation of therapy with Keveyis?  Yes  No *If No, skip to #6*
- Is the patient currently receiving Keveyis through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to #6*  Yes  No  Unknown
- Is the patient experiencing a response to Keveyis therapy as demonstrated by an improvement of their condition (e.g. decrease in the number or severity of attacks)?  Yes  No *No further questions.*
- Has the patient tried and had a suboptimal response to treatment with acetazolamide?  Yes  No

**Complete the following section based on the patient's diagnosis, if applicable.**

#### Section A: Primary Hypokalemic Periodic Paralysis

- Was the diagnosis confirmed with at least one of the following criteria: 1) genetic testing, 2) family history of primary hypokalemic periodic paralysis or 3) ruling out the diagnoses of both Andersen-Tawil syndrome and thyrotoxic periodic paralysis?
  - Yes, genetic testing
  - Yes, family history of hypokalemic periodic paralysis
  - Yes, ruled out diagnoses of Anderson-Tawil syndrome AND thyrotoxic periodic paralysis
  - No
- Are the patient's attacks associated with hypokalemia?  Yes  No

#### Section B: Primary Hyperkalemic Periodic Paralysis

- Was the diagnosis confirmed with at least one of the following criteria: 1) genetic testing, 2) family history of primary hyperkalemic periodic paralysis or 3) ruling out the diagnosis of Andersen-Tawil syndrome?

**Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155**

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- Yes, genetic testing
- Yes, family history of hyperkalemic periodic paralysis
- Yes, ruled out diagnosis of Anderson-Tawil syndrome
- No

10. Are the patient's attacks associated with hyperkalemia?  Yes  No

*I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.*

X \_\_\_\_\_  
Prescriber or Authorized Signature Date (mm/dd/yy)

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