Pharmacy Drug Policy Checklist

POLICY NAME	Keveyis (dichlorphenamide)	POLICY #	2447P

Criteria

Coverage Criteria

- ☐ **1.1** Documented diagnosis of primary hyperkalemic periodic paralysis or primary hypokalemic periodic paralysis, or related variants of primary periodic paralysis (episodes of muscle weakness with or without high or low potassium levels)
- ☐ **1.2** Prescribed by a specialist experienced in treating periodic paralysis
- ☐ **1.3** Documented failure, intolerance, or contraindication to acetazolamide
- ☐ **1.4** If primary hyperkalemic periodic paralysis, documented failure, intolerance, or contraindication to thiazide diuretics (hydrochlorothiazide)
- ☐ **1.5** If primary hypokalemic periodic paralysis, documented failure, intolerance, or contraindication to both spironolactone and triamterene as well as potassium supplementation
- ☐ **1.6** Coverage of brand Keveyis requires previous trial or contraindication of generic dichlorphenamide