Effective Date: 08/01/2019
Reviewed: 05/2020, 3/2021, 3/2022, 3/2023, 3/2024 Scope: Medicaid

dichlorphenamide

POLICY

I. CRITERIA FOR APPROVAL

For all indications:

An authorization of 2 months may be granted when all the following criteria are met:

- Patient is 18 years of age or older
- Medication is prescribed by, or in consultation with neurologist
- Maximum daily dose does not exceed 200mg
- The patient does not have hepatic impairment, metabolic acidosis, severe pulmonary disease (e.g., severe COPD), and is not concomitantly taking high-dose aspirin (doses greater than 325mg/day)
- The patient must have an inadequate treatment response, intolerance or contraindication to acetazolamide; **AND**

Primary Hypokalemic Periodic Paralysis

A. The diagnosis must be supported by at least one of the following:
   a. Genetic test results
   b. Patient has a family history of primary hypokalemic periodic paralysis
   c. Patient's attacks are associated with hypokalemia AND both Andersen-Tawil syndrome and thyrotoxic periodic paralysis have been ruled out; **OR**

Primary Hyperkalemic Periodic Paralysis

B. The diagnosis must be supported by at least one of the following:
   a. Genetic test results
   b. Patient has a family history of primary hyperkalemic periodic paralysis
   c. Patient's attacks are associated with hyperkalemia AND Andersen-Tawil syndrome has been ruled out

II. CONTINUATION OF THERAPY

Authorization of 12 months may be granted for all patients when all of the following criteria is met:

A. Medication is prescribed by, or in consultation with neurologist
B. Maximum daily dose does not exceed 200mg
C. Patient has documented diagnosis of primary hyperkalemic periodic paralysis, primary hypokalemic periodic paralysis, or related variants
D. The patient does not have hepatic insufficiency (e.g., Child-Pugh Class A)
E. The patient does not have severe pulmonary disease (e.g., severe COPD)
F. The patient has a positive clinical response to the medication as evidenced by reduced frequency of paralysis and continues to require ongoing therapy

III. QUANTITY LIMIT

dichlorphenamide 50mg tablets: 4 tablets per day

IV. COVERAGE DURATION

- Initial: 2 months
- Renewal: 12 months

V. REFERENCES

1. Keveyis [package insert]. Feasterville-Trevose, PA: Strongbridge Biopharma; December 2021.
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3. Available at: http://www.micromedexsolutions.com. Accessed December 11, 2019.
4. Lexicomp Online®, Lexi-Drugs®, Hudson, Ohio: Wolters Kluwer Clinical Drug Information, Inc.; http://online.lexi.com Accessed December 11, 2019.
5. Clinical Pharmacology [database online]. Atlanta, GA: Elsevier, Inc.; 2019. https://www.clinicalkey.com/pharmacology. Accessed December 11, 2019.
6. Lexicomp Online®, AHFS® Drug Information, Hudson, Ohio: Wolters Kluwer Clinical Drug Information, Inc.; http://online.lexi.com Accessed December 11, 2019.