

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

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

IV. COVERAGE DURATION

- Initial: 2 months
- Renewal: 12 months

V. REFERENCES

1. Keveyis [package insert]. Feasterville-Trevose, PA: Strongbridge Biopharma; March 2025.
2. Micromedex Solutions [electronic version]. Truven Health Analytics, Greenwood Village, Colorado.
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.